SELF-GUIDED PRACTICE WORKBOOK [N18]
CST TransformationalLearning

WORKBOOK TITLE:

Provider: Pediatric

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	■ This is a self-paced learning session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Each scenario will allow you to work through different learning activities at your own pace to ensure you are able to practice and consolidate the skills and competencies required throughout the session.
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

Using Train Domain

You will be using the train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

- Scenarios and their activities demonstrate the CIS functionality not the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Access and Set-up

Learning Objectives

At the end of this Scenario, you will be able to:

- Access a patient's chart and review patient care information.
- Place and manage admission orders.
- Review and manage medications on admission.
- Complete patient's admission and document patient care.

SCENARIO

As the provider covering the Pediatric Medicine Unit, you receive a phone call from the Emergency Department provider, who requests a new patient consult. A 7 year old male with history of asthma has presented to the ED with fever and a productive cough. He weighs 25 kg and has an allergy to penicillin.

The following steps are required for patient's admission when using the Clinical Information System (CIS).

1. Placing an **Admit to Inpatient** order
2. Reviewing the patient's **Best Possible Medication History (BPMH)** and completing admission medication reconciliation
3. Placing admission orders
4. Creating an admission note

You will complete the following activities:

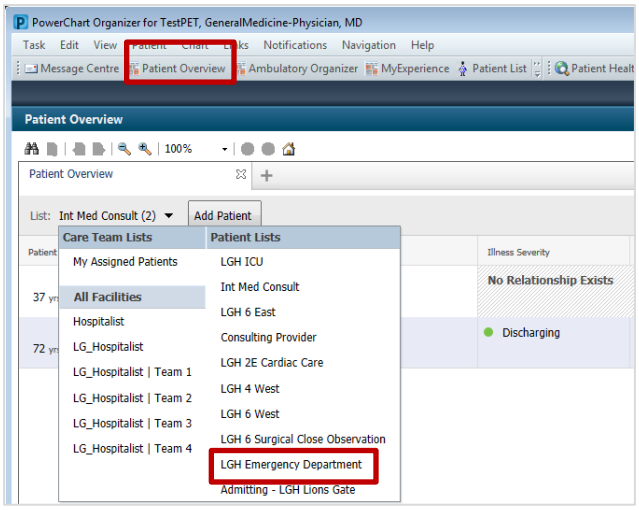
- Access and review the patient chart
- Review home medications and complete admission medication reconciliation
- Place orders through PowerPlans (order sets) for patient admission
- Update problems and diagnoses and document your assessment findings
- Complete and sign an admission note

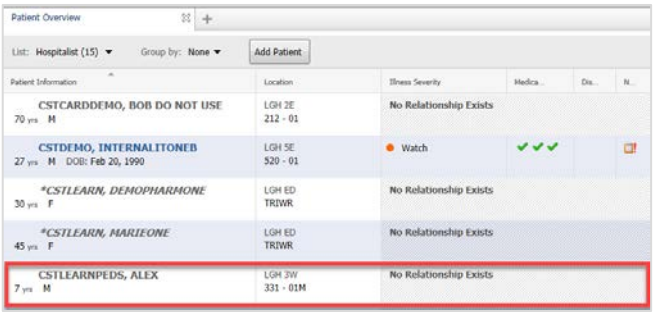
Activity 1.1 – Access and Navigate Patient Chart

When you log into the CIS, the very first screen is Message Centre, which serves as a collaboration and communication platform similar to email.

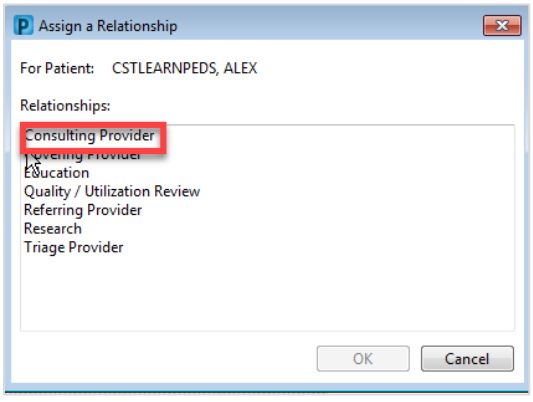
You want to open your patient's chart. The simplest way is to use Patient Overview. The CIS can maintain the list of patients that are currently in the **Emergency Department** and other areas of the hospital. You can display all your lists under the **Patient Overview**. You will learn about the Patient Overview and patient lists later.

To access the chart, simply click the patient's name from the list.





When you access the chart for the first time, you are prompted to **Assign a Relationship** with the patient. To consult on the ED patient, select **Consulting Provider** and click **OK.**



After reviewing the patient chart and assessing the patient, you can decide whether to admit them.

If you do not admit them you will create a consult note and close the chart. If you admit them the first step you need to take is to place the **Admit to Inpatient** order.

It is important that the Admit to Inpatient Order is placed **before** any other orders. Pharmacy dispensing may be delayed if this order is not placed first. Also, placing this order allows the following important steps to happen automatically:

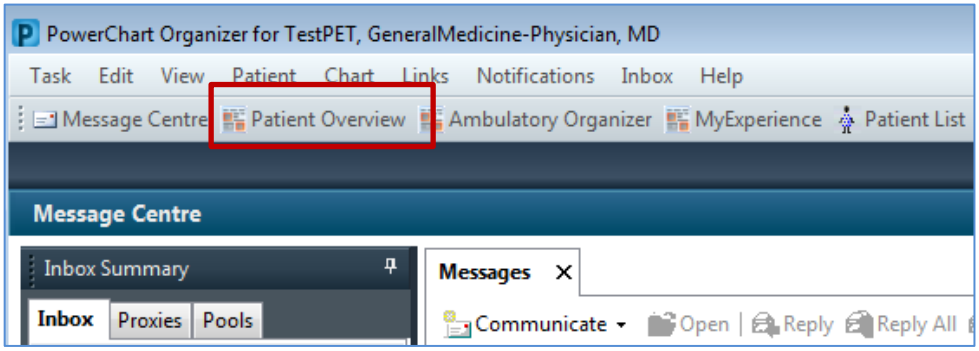
- The status of the patient becomes inpatient and the clock starts for the admission
- There is a notification to Access Services to locate a bed for the patient
- The encounter type changes from Emergency to Inpatient.
- Admission tasks are sent to the inpatient nurse assigned to this patient

In our scenario, you made the decision to admit the patient. As you are using the learning domain, the **Admit to Inpatient** order has already been placed. A bed became available on the pediatric unit and your patient was transferred there. You are now designated as their attending provider. From here you will practice navigating his patient chart.

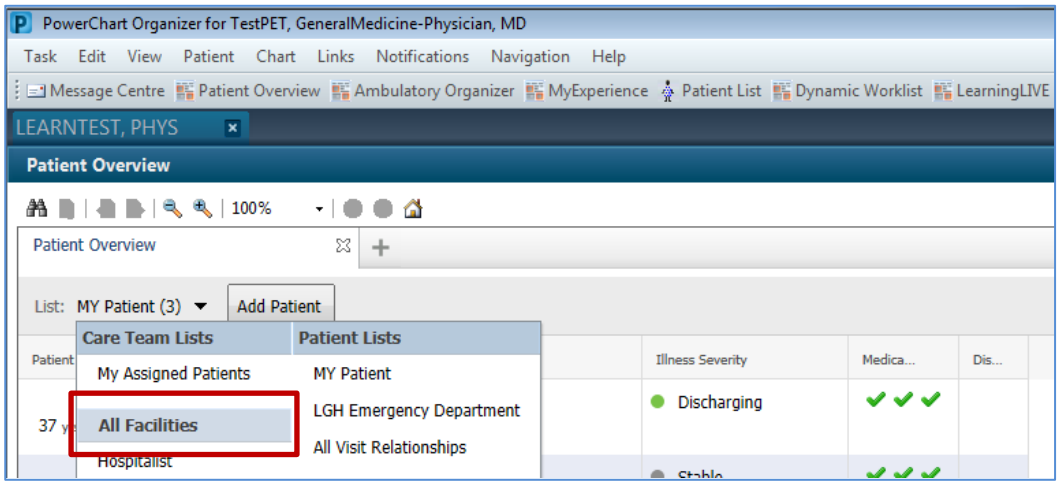
NOTE: The completion of the Admit to Inpatient order involves actions taken by other hospital departments. Such a process cannot be fully represented in the Train Domain and **patients in the Train Domain are already admitted** to the Pediatrics Unit. You will place the Admit to Inpatient order for practice only.

- If you had decided **not to admit** the patient, you would create a consult note and close the chart.

1 To access and review the patient chart, click **Patient Overview**.

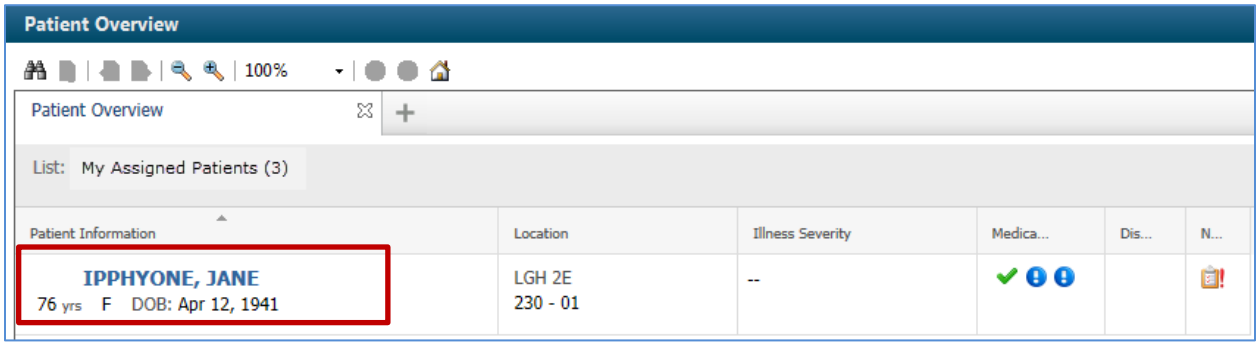


2 Select the **My Assigned Patients** list which groups together all patients for whom you are the attending provider.



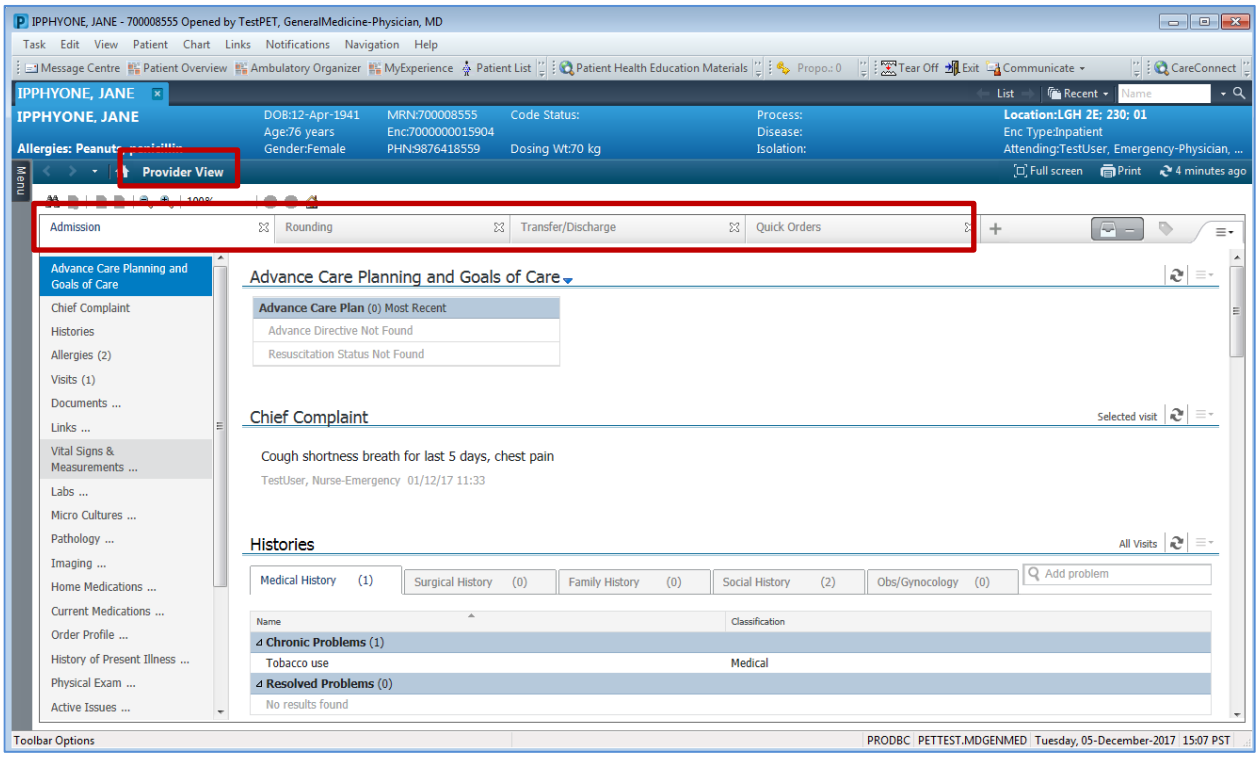
Note: There are other ways of accessing a patient's chart that can be learned from other resources.

3 Under **My Assigned Patients** click your patient's name to access the chart.



4 The patient's chart opens to the **Provider View** which is the current default screen when accessing a patient's chart.

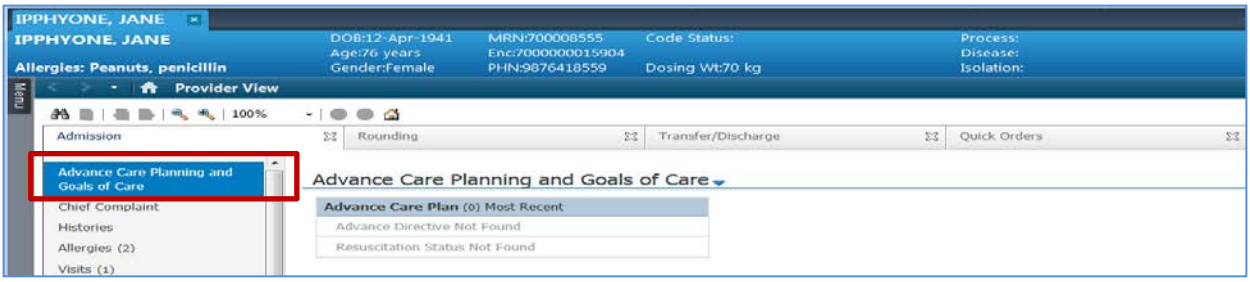
It is organized into several tabs. Each tab is designed to support a specific workflow. Click each tab to open a specific view.



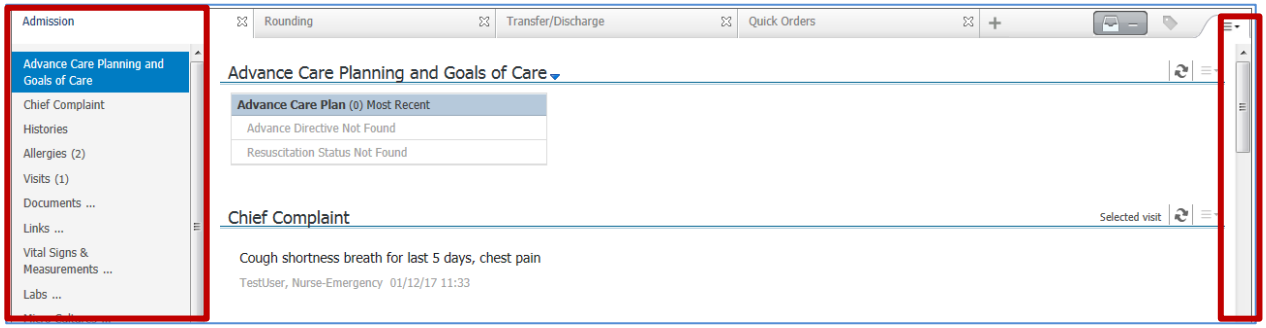
5 The **Banner Bar** located at the top of the screen displays demographic data, alerts, information about the patient's location, and current encounter.

Click the **Refresh** icon to ensure that your display is up-to-date. A timer shows how long ago the information on your screen was last updated. Refresh frequently.

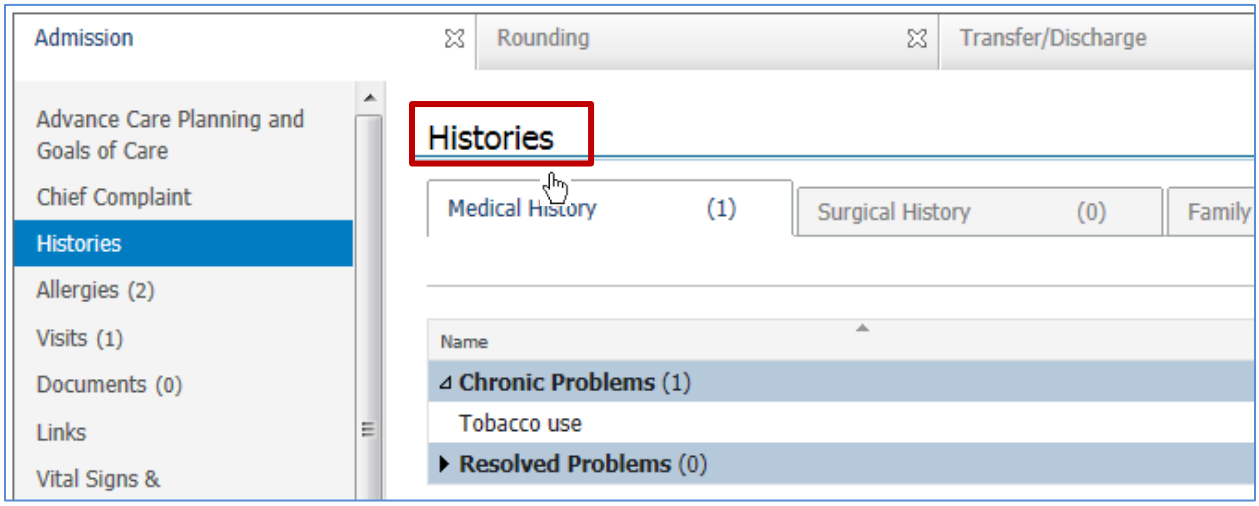
6 Open the **Admission** tab to start the admission process.



7 On the left side of the screen there is a list of components representing workflow steps specific to your specialty. Click the component name or use the scroll bar to view specific information within each of the components.



8 Each component has a heading. Place the cursor over the heading. This icon means the heading is an active link. Click this heading to open a comprehensive window with more options.



9 If the patient already has previous encounters in the CIS, you will have access to patient information previously documented such as allergies, histories and notes from previous visits.

With the patient's chart displayed on your screen, review the information entered by the ED team. Ensure you are on the Admission tab and navigate through the component list in order. Review the following components for your patient:

- Chief Complaint
- Histories
- Allergies
- Documents
- Vital Signs
- Lab results
- Home Medications
- Current Medications

Key Learning Points

- When admitting a patient it is critical to place the **Admit to Inpatient** order prior to entering additional orders.
- Use the **Patient Overview** and specific patient lists to access patient charts.
- Review the **Banner Bar** information to ensure you have selected the right patient and the right encounter.
- Remember to **refresh** your screen frequently to view the most up-to-date information.
- The **Provider View** provides access to various workflow tabs.

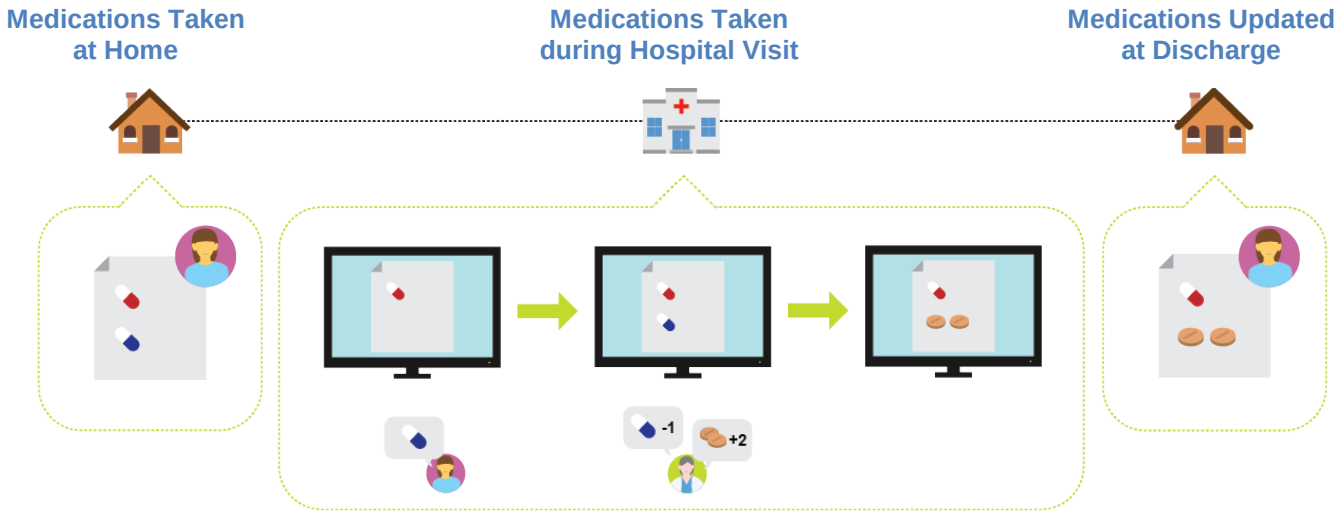
Activity 1.2 – Review Best Possible Medical History (BPMH)

The BPMH is generally documented by a pharmacy technician. When a pharmacy technician is not available, it can be completed by a pharmacist, nurse, medical student, resident, or by the patient's most responsible physician.

In the CIS there are two places to see a list of home medications. You can look in the Home Medication component of the **Admission** workflow. This will show you the medications that the patient was taking upon discharge from their last encounter.

You can also see the patient's PharmaNet Profile when documenting the BPMH. When you create the BPMH, these lists can be seen side-by-side. More details about how to view the PharmaNet profile and complete the BPMH will be shown in other training sessions.

Home medications are reconciled each time the medication reconciliation is done.



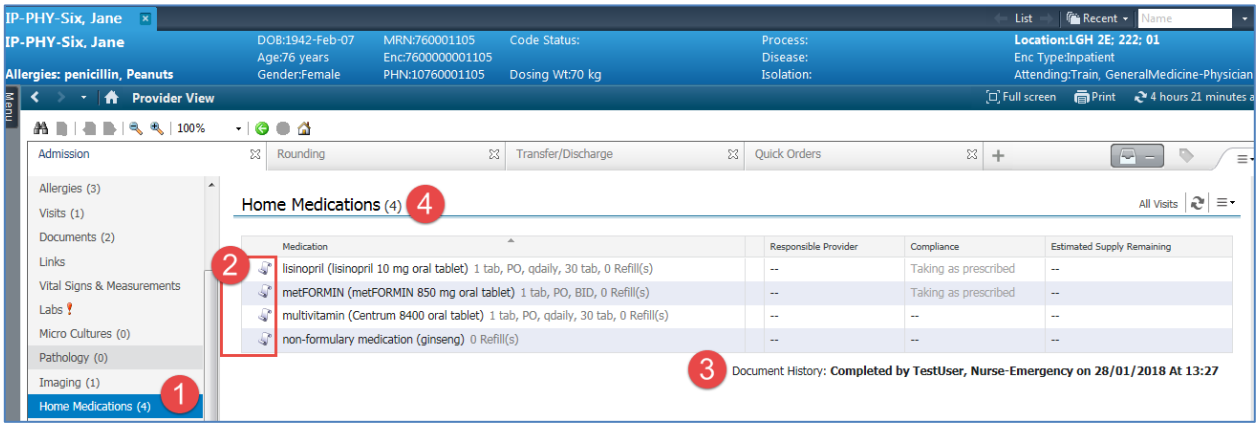
WARNING: In the CIS, the BPMH **must be completed before** proceeding with the admission medication reconciliation. The Admission Reconciliation will not be available until the Medication History is documented.

In our scenario, the pharmacy technician documented home medications. Jane's daughter brought Jane's *gliclazide* and *salbutamol inhaler* with her from home and you decided to document them to complete the admission reconciliation.

Ensure you are in the **Admission** tab:

1. Click the **Home Medications** component to display the list of documented home medications.

2. Documented home medications are marked by the  icon.
3. Note the status line indicating who and when updated the medication history.
4. Click the **Home Medications** heading.

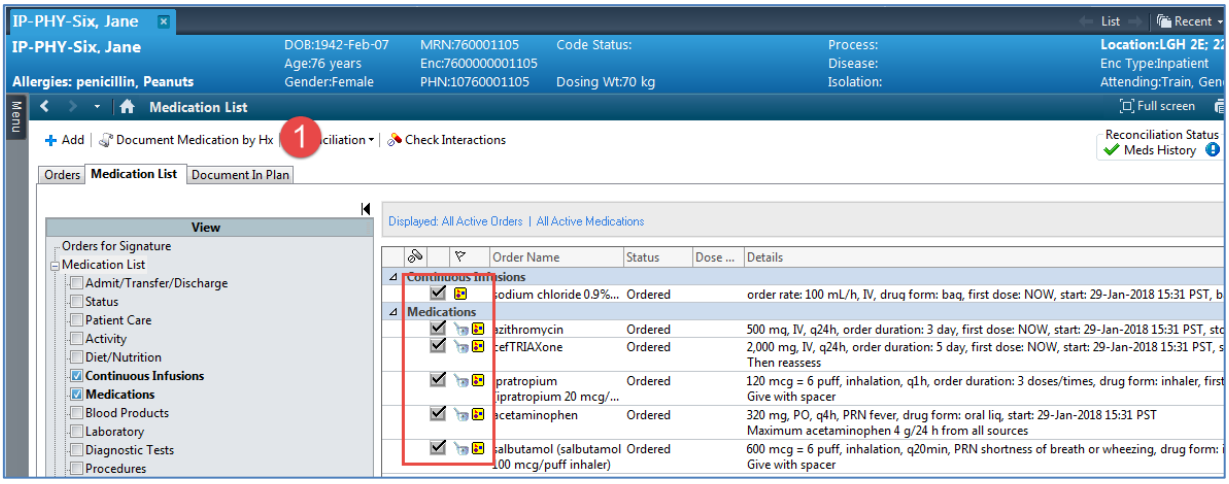


2 The **Medication List** window displays and you can check details for **all current** medications prescribed for the patient.

Hover to discover to check what on-screen explanation is provided:

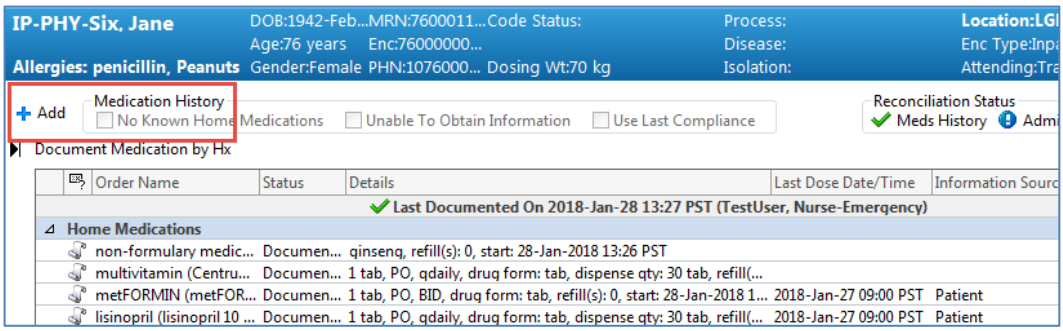
- indicates inpatient medication
- indicates medication is part of the order set; Hover to discover more information.
- indicates that pharmacy must verify the medication

1. Click **Document Medication by Hx**.



3 Ensure you are in the Medication History window. Click the + Add button on the

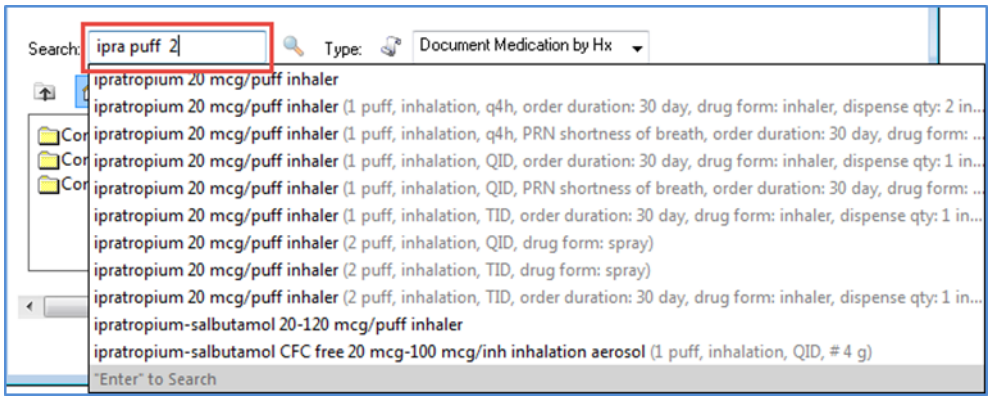
Medication History toolbar.



4

In the **Search** window you can search the entire catalogue.

1. You may need some practice to be able to use the search efficiently. Here are few tips:
   - Type few first characters.
   - Add more details to truncate the list of possible options.
   - For this example, type ***ipra puff 2*** to add **Ipratropium 20 mcg/puff inhaler (2 puff QID**).
2. Select the most detailed and appropriate order sentence to avoid manual entries
3. Once you select the medication and associated details (order sentence), the medication order is placed and waiting for your signature. You can continue searching and adding more medication orders if needed.
   For this activity, you want to add just this one. Click **Done**.

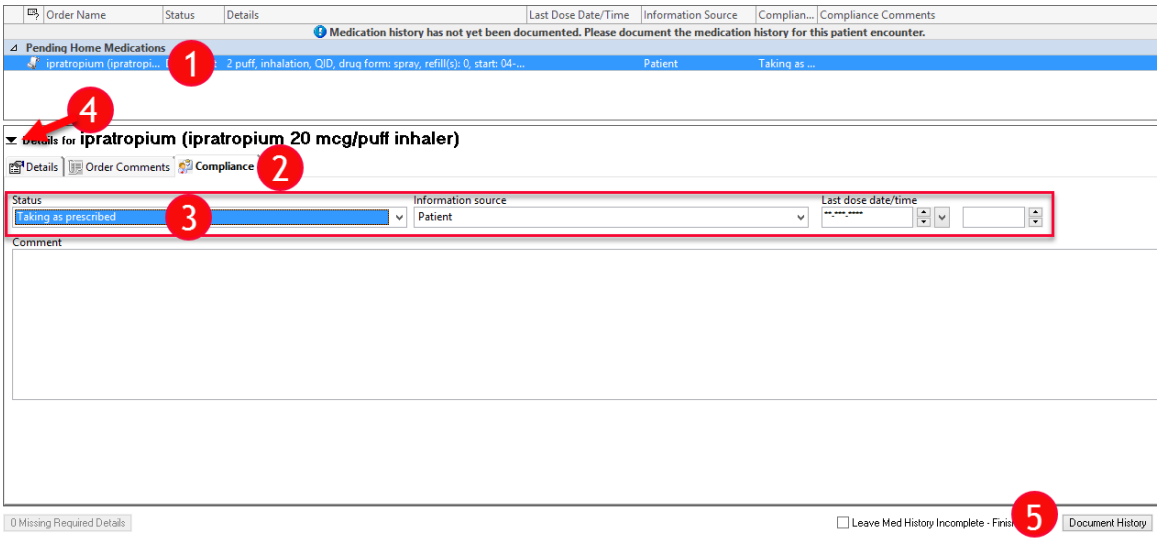


5

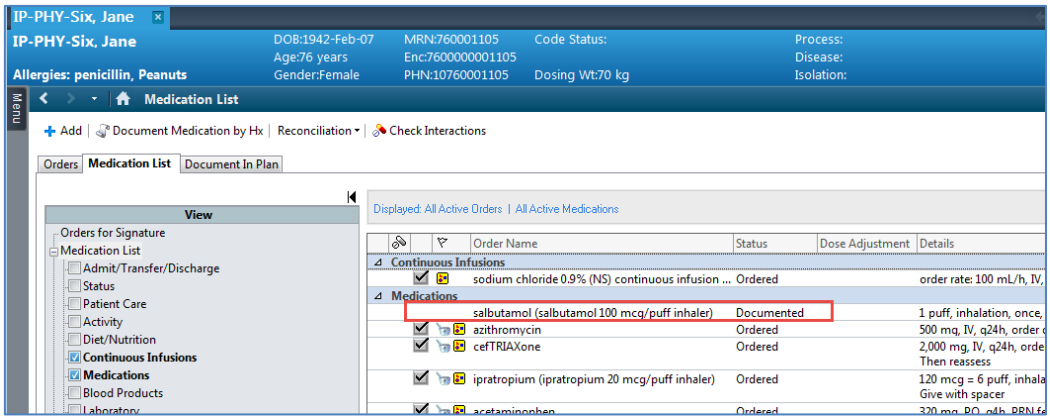
1. Select the order to display its details.
2. It is very important to know if the patient is compliant with prescription. To add this information, click on the **Compliance** tab.
3. Document the following in the **Compliance** tab:
   - **Status** = Taking as prescribed

- Information source = *Patient's mother*
- **Last dose date/time**= *Yesterday at 0900,* use calendar to enter date in a proper format

4. Click Details to collapse or expand details for the selected order.
5. Click **Document History** to complete the process.



6 The updated list of current home medications displays.



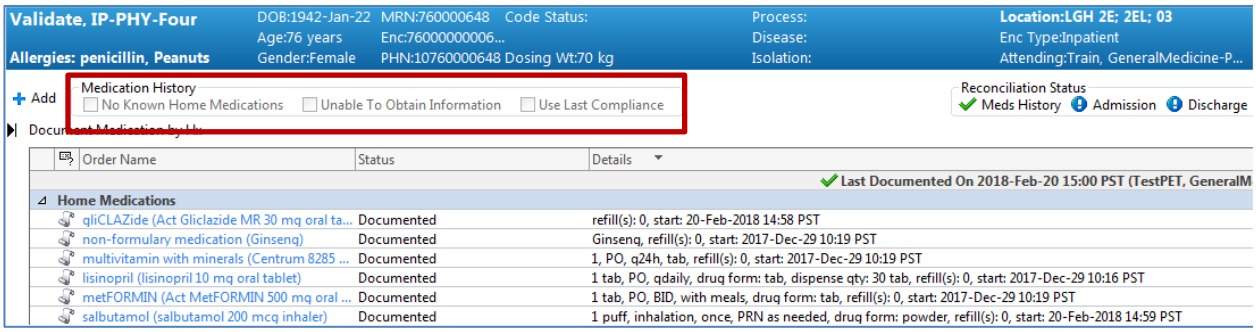
7 For your practice, try using this process to add **multivitamin with minerals, PO, qdaily, tab**. You will complete the medication reconciliation for both of these medications in the next activity.

In some cases, you may need to document that the patient has no home medications or you are unable to obtain information. Select Document Medication by Hx

When needed, you can select one of the following options:

- **No Known Home Medications**

- **Unable to Obtain Information**
- You can also select the medication and click **Use Last Compliance** – this will copy the past medication record as a current entry

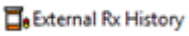


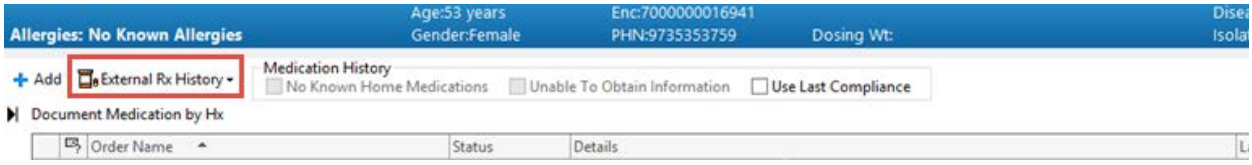
8 Providers will occasionally update the home medications because there will be Pharmacy Techs but this is very important for patient safety.

NOTE: The following information and screenshots are to illustrate the ability to see a patient's PharmaNet profile when completing BPMH.

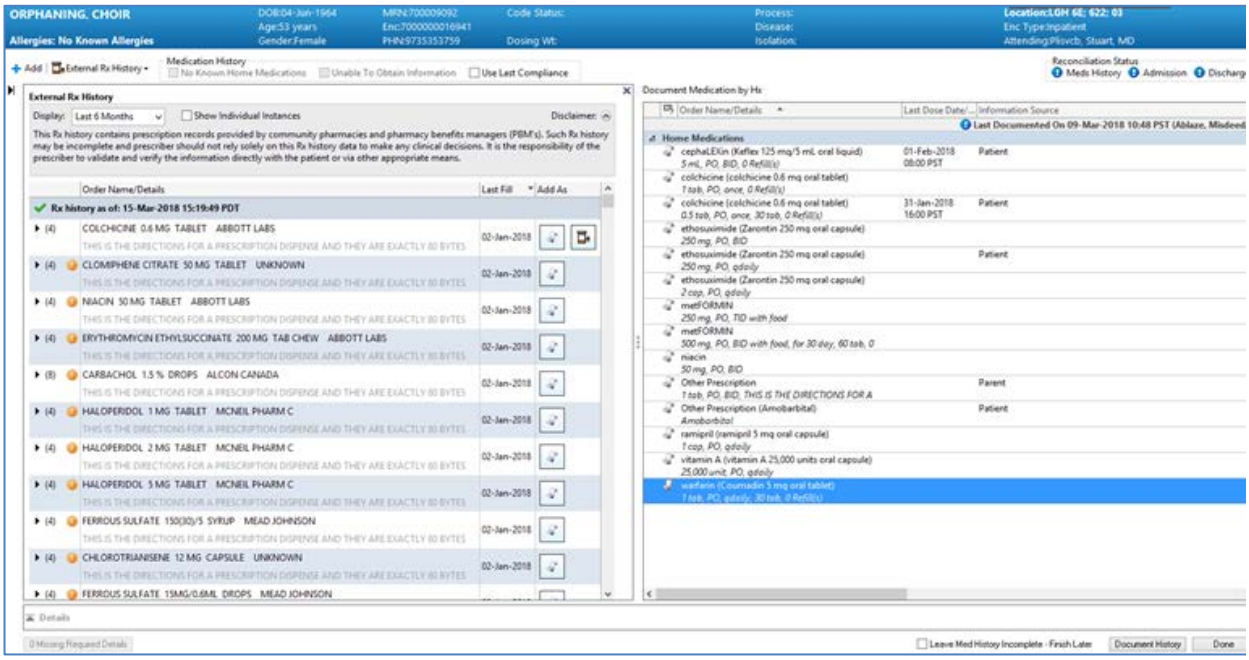
This is **not available** in the Train domain that you are currently learning in, but will be available when the CIS goes live. Resources to review this process will be available in future sessions prior to go-live.

9 To view a patient's PharmaNet profile, you will access home medications in a similar manner as above, by selecting the **Document Medications by Hx** button. 

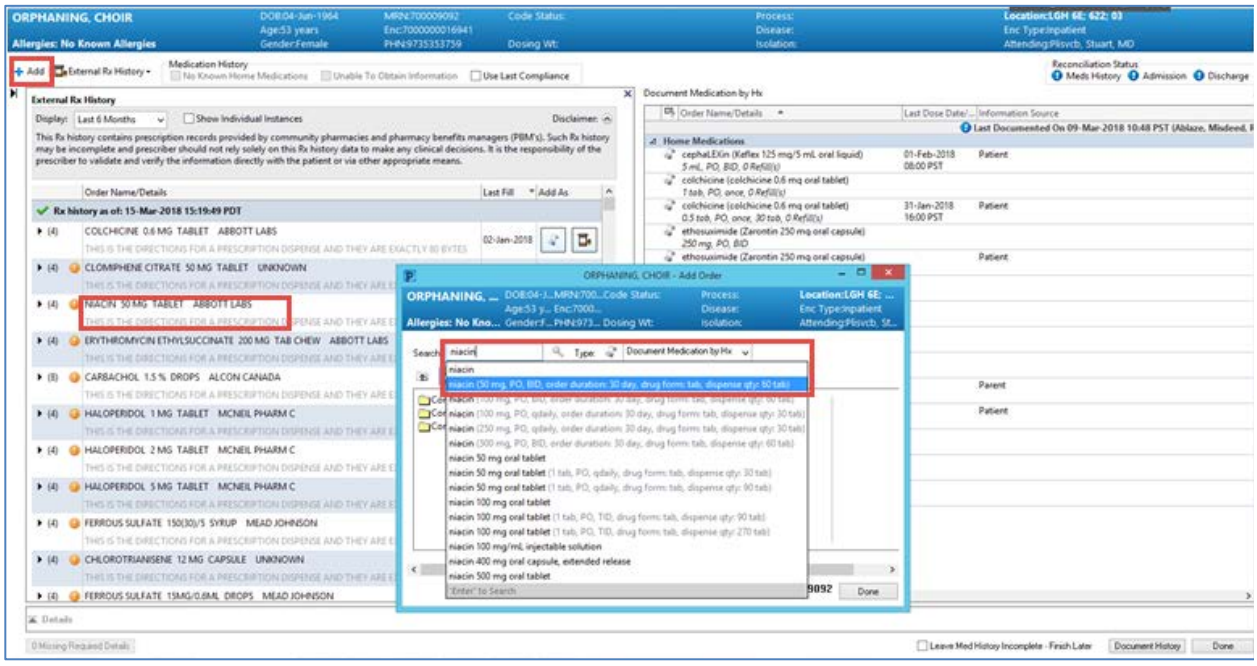
Within the Document Medications by Hx page, a new **External Rx History** button will be visible. 



Clicking this button will open up the PharmaNet External Rx History window in a side-by-side view with the Document Medication by Hx window.



From these windows, users can then review a patient's PharmaNet history and make informed decisions regarding which medications to add to the patient's BPMH.

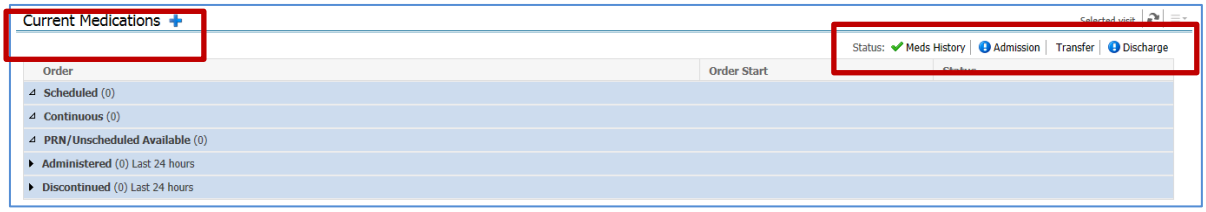


Key Learning Points

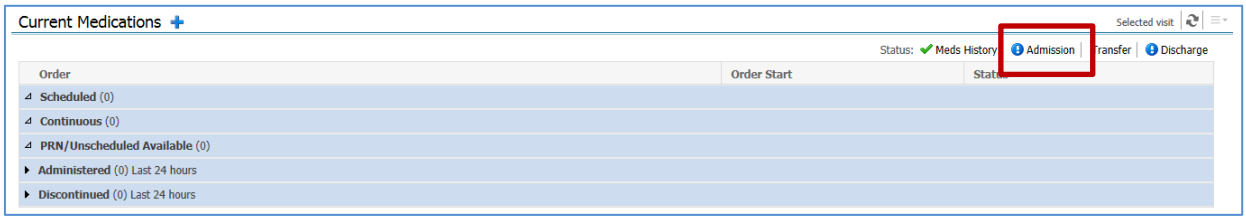
- **BPMH** must be completed **before** admission medication reconciliation can occur
- Home medications, once documented, can be updated at any time
- Documented home medications can be continued during the hospital visit
- Documented home medications can be continued or stopped when patient is discharged

Activity 1.3 – Complete Admission Medication Reconciliation

1 With the BPMH completed, you can start admission reconciliation.
Move to the next component – **Current Medications** – indicating the status of medication management in patient's chart.



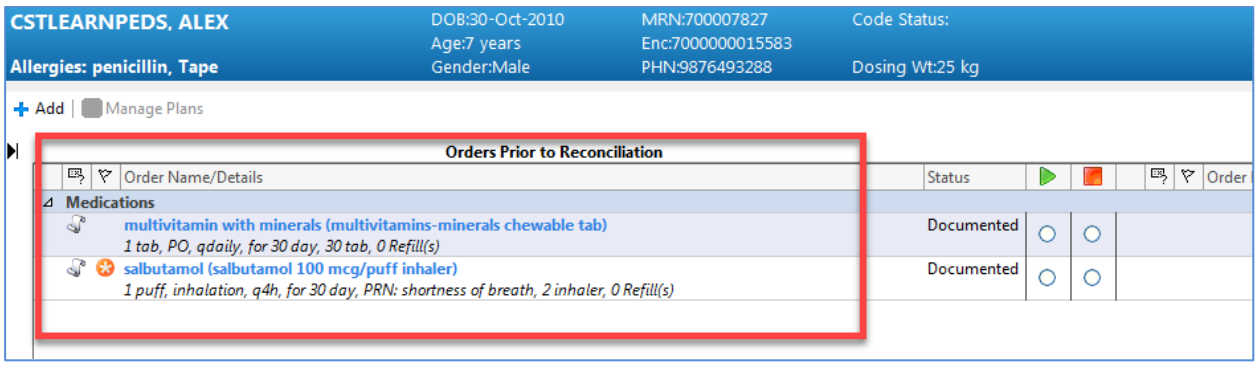
2 To complete admission medication reconciliation, click the **Admission** button.



3 The admission reconciliation screen for the patient displays.

Check the **Orders Prior to Reconciliation** on the left. It lists:

- Documented home medications from the BPMH
- Medications ordered in hospital
- Active medications from other encounters such as outpatient, oncology etc.



Hover over icons to learn more about them:

indicates ?

indicates ?

indicates ?

allows for ?

allows for ?

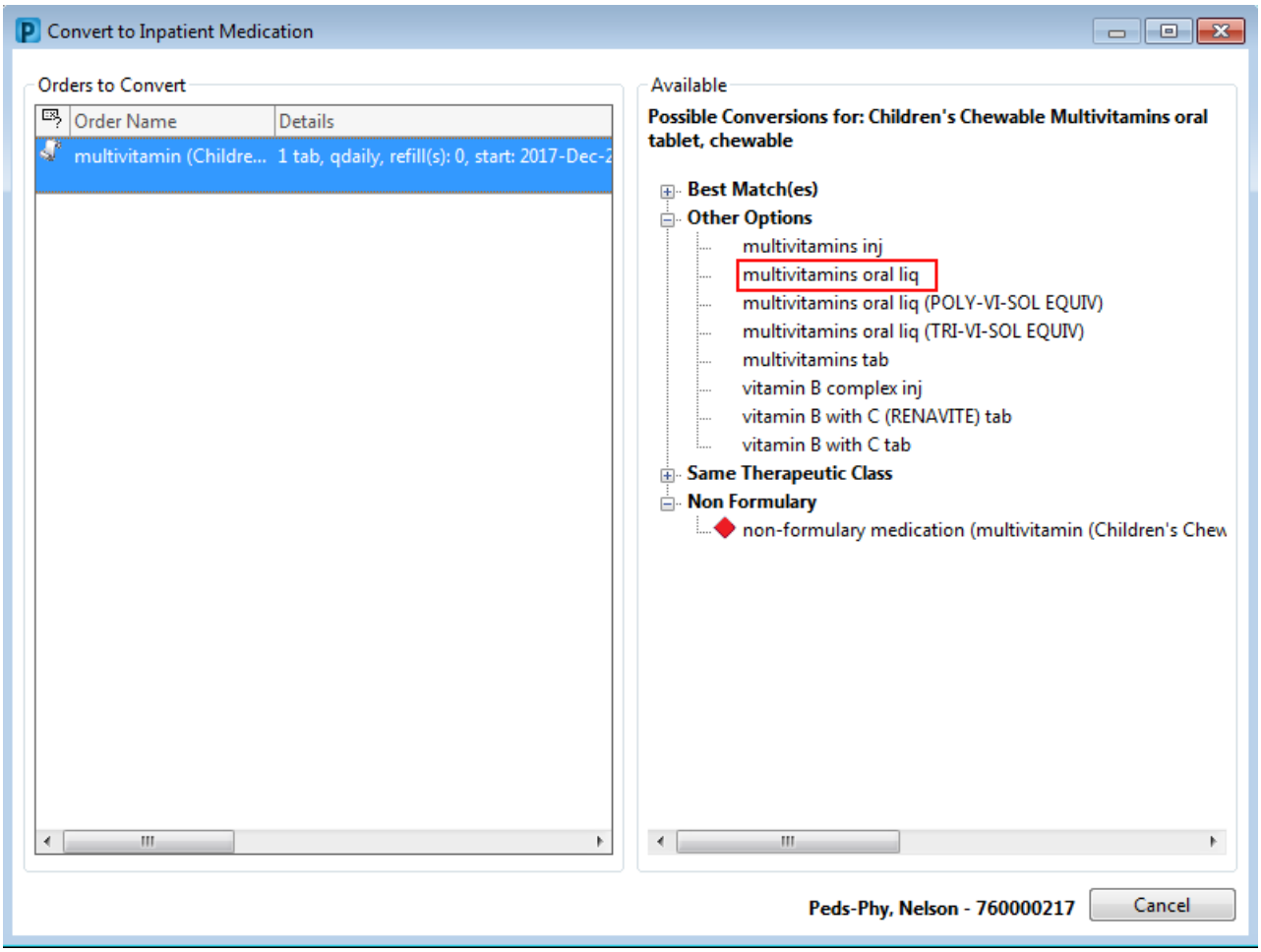
Note: If the patient received a paper prescription medication on a previous visit, it will be marked by the icon.

4 In the Admission Reconciliation, discontinue the following medications:

- Sodium chloride 0.9% (NS) continuous infusion 1000 mL rate of 30 mL/hr

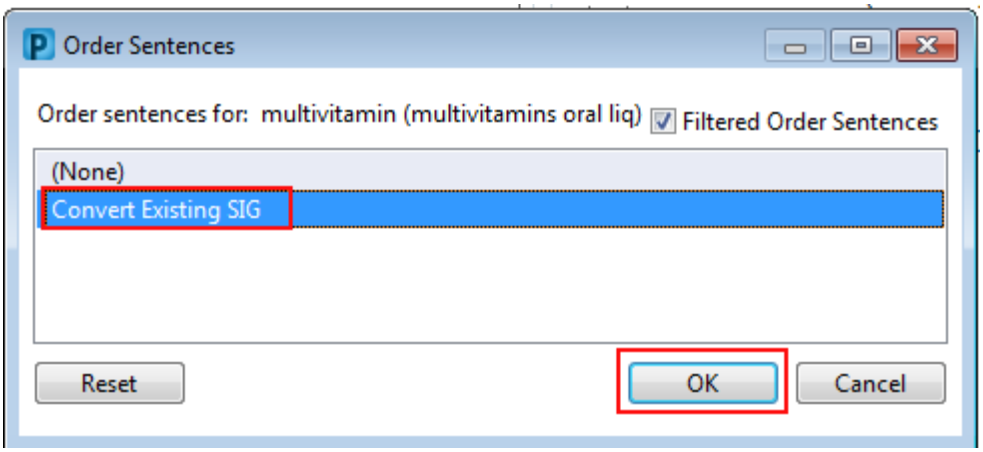
5 For all other medications, select **Continue**.

If a patient has a medication where a conversion or non-formulary substitution needs to occur, you will receive a pop-up notification when that medication is selected to continue. Select the substitution option you desire, in this case **multivitamins oral liq**.



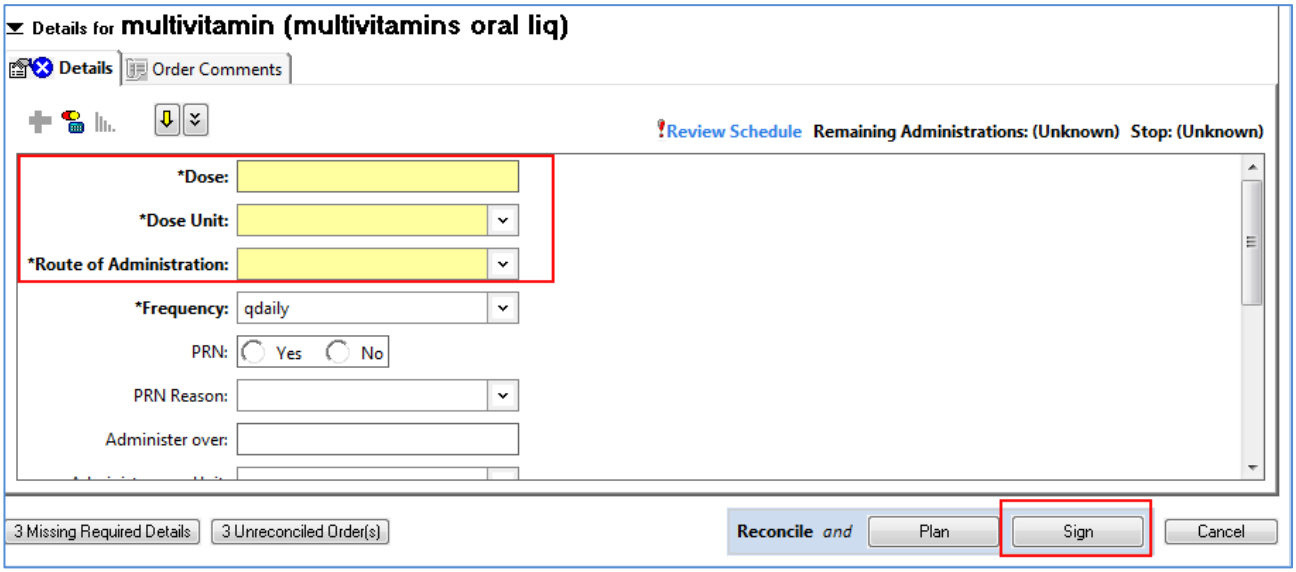
An additional window will appear for selecting an order sentence to complete the order. For this

example, select **Convert Existing SIG** and click **OK**.



You will return to the medication reconciliation window and a red exclamation mark icon will appear beside the **multivitamin order** to address the details needed for the conversion.

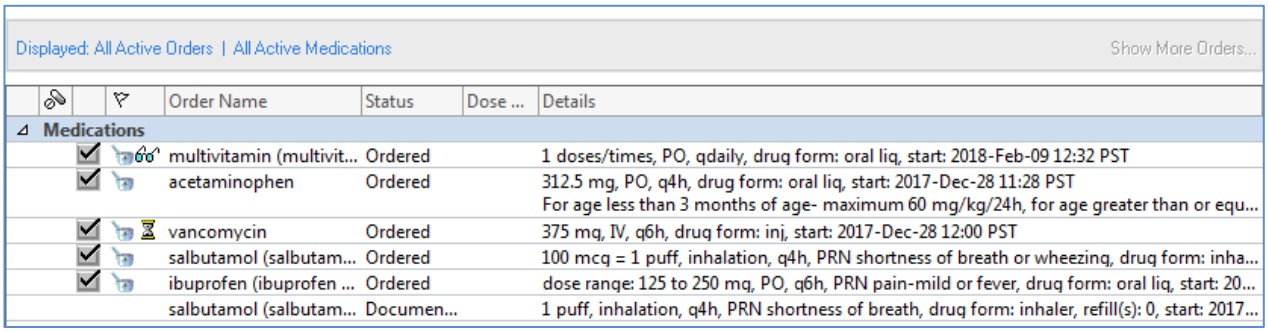
- Click the **exclamation mark** . A window will open to modify the order details.



Fill in the yellow required fields:

- **Dose=***1*
- **Dose Unit=***doses/times*
- **Route of Administration**=*PO*
- **Drug Form**= *oral liq*
- **Start Date/Time**= *T (for Today)*
-

Then click **Sign**. You will return to the Medication orders list.
Refresh the page to see the new orders.



Note: It is more efficient to complete admission medication reconciliation **before** placing any new orders. This way you are only reconciling the patient's documented home meds and recently ordered meds from the ED.

Activity 1.4 – Place a PowerPlan (Order Set) for Patient Admission

Now you are ready to place orders for your patient. You will use a PowerPlan that is specifically designed for admitting patients to the pediatric medicine unit.

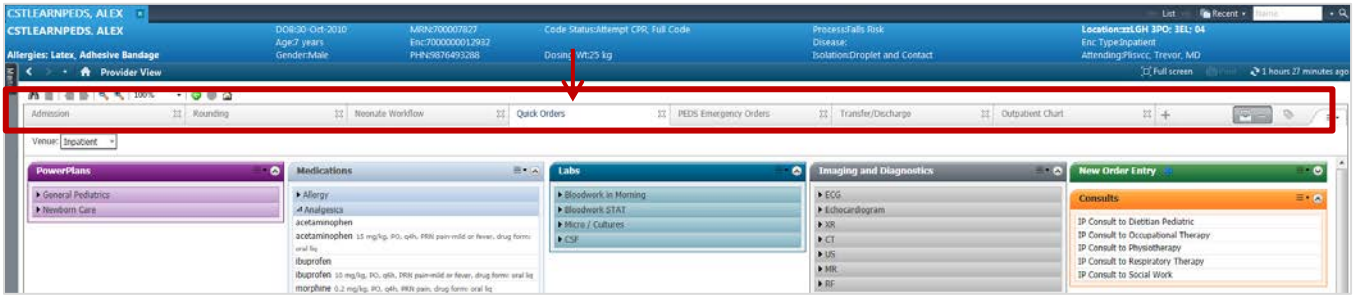
PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

1. You can select and deselect individual orders from the PowerPlan list.
2. You can add orders that are not listed in the PowerPlan.
3. You can add other modules (orders sets) that are a listed in a PowerPlan.

An **Initiated** PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members. If you want something to happen now, use the **2 step process**: first Initiate then Sign**.**

A PowerPlan that is only **Signed** but **not Initiated**, remains in a **Planned** state allowing you to prepare orders for a future activation as needed. This is useful for surgical scenarios and for future procedures. If you want something to happen later**,** use 1 step only: Sign.

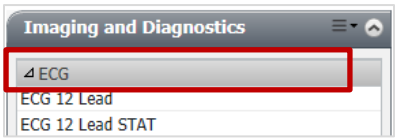
The best option for placing PowerPlans and orders is via the **Quick Orders** tab. This view is an one-stop shop for common orders and PowerPlans that are specialty specific. It is organized into separate categories such as Medications, Labs etc. Depending on your specialty, it may differ which orders are available and how orders are organized.



Under each category, there are folders. For example, under the Medications category there is the Analgesics folder which contains individual orders for analgesic medications such as acetaminophen. Orders may allow you to add additional details regarding dose, frequency, route, etc., or may have these details pre-determined for ease of ordering as an order sentence.

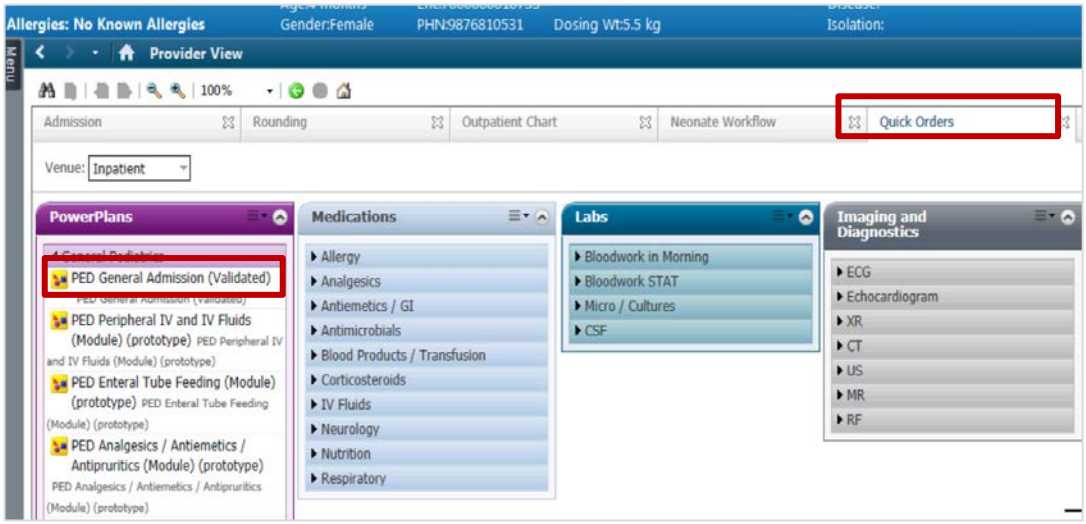
Clicking the arrow will collapse or expand the category.

Clicking the folder will collapse or expand its content.



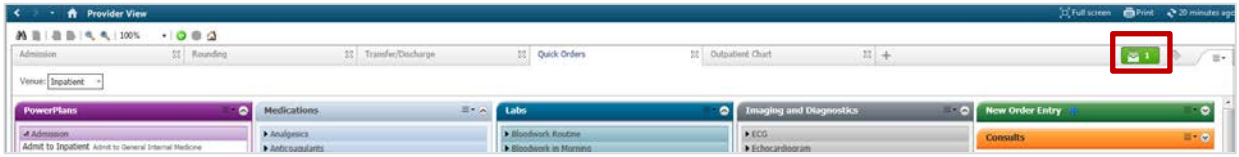
Placing the PowerPlan

1 In the **Quick Orders** tab, under the **PowerPlan section,** expand the **General Pediatrics** folder. Select **PED General Medicine Admission**. PowerPlans are marked by the icon.

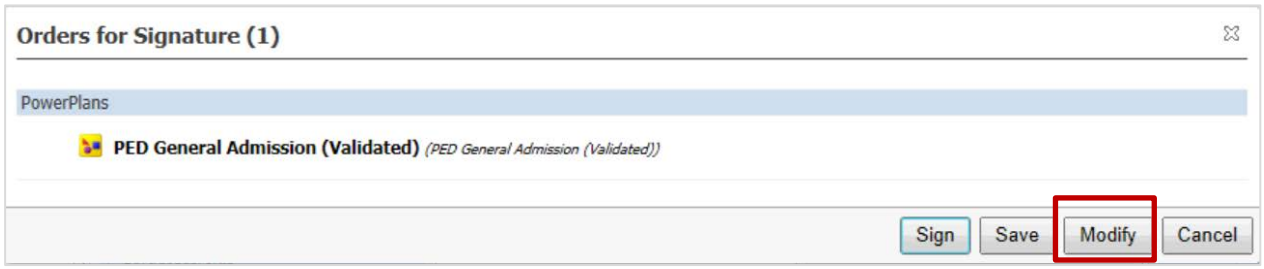


2 Click the **Orders for Signature** icon 

.

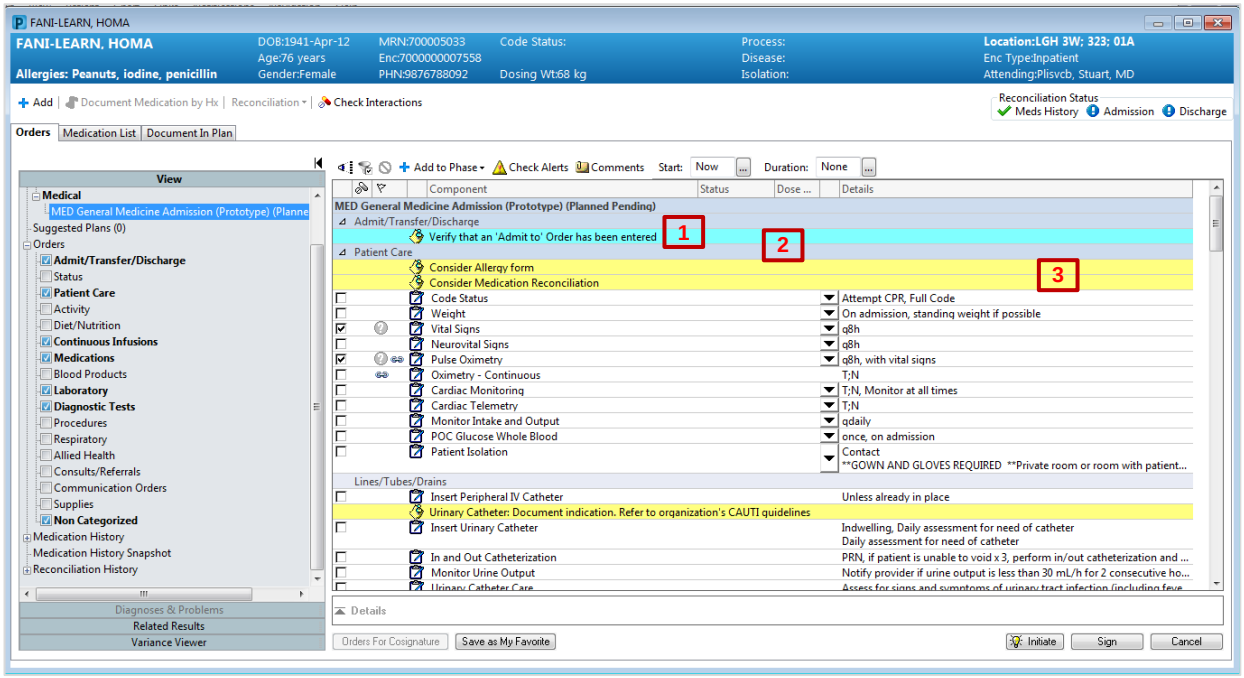


3 Click **Modify**.

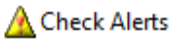


4 PowerPlans open in the Plan Navigator. Scroll through to locate visual cues organizing orders:

1. Bright blue highlighted text for critical reminders.
2. Light blue highlights that separate categories of orders.
3. Bright yellow highlights for clinical decision support information.

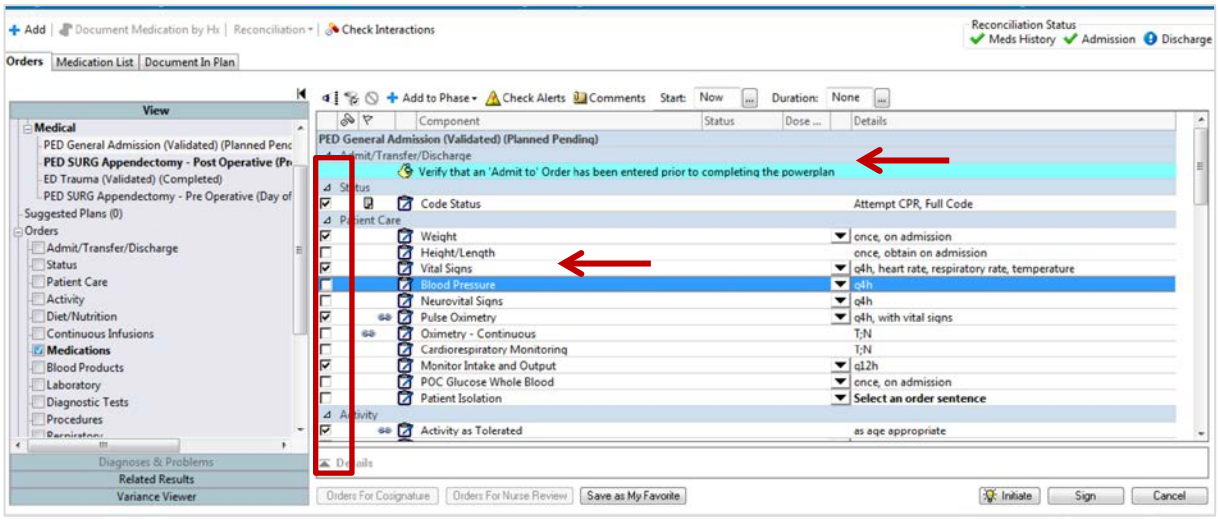


Hover over the icons along the top toolbar:

	**Merge View –** Displays the plan components with those already ordered for the patient and active on the patient profile.
	**Filter View** – Shows only checked orders, allowing users to see only the orders you have selected.
	**Initiate Plan or Phase –** Initiates the selected plan or phase. Orders do not become active or route to ancillary departments until you initiate.
	**View Excluded –** Displays components of the predefined plan that were not included in the initiated plan.
	**Discontinue –** Opens the Discontinue dialog box so that you can discontinue the plan or phase (individual components can be kept).
	**Plan Comment –** Adds a note to a PowerPlan phase. Plan comments allow you to communicate decisions made regarding the phase to other clinicians who can view or take action on the phase. You can add a comment to a phase in any status.
	**Check Alerts –** Allows you to check for Quality Measure Alerts.

Modifying the PowerPlan

1 Click the corresponding box to select or deselect individual orders from the PowerPlan. Some orders are already pre-selected for efficiency but you can click the box to deselect, if necessary.

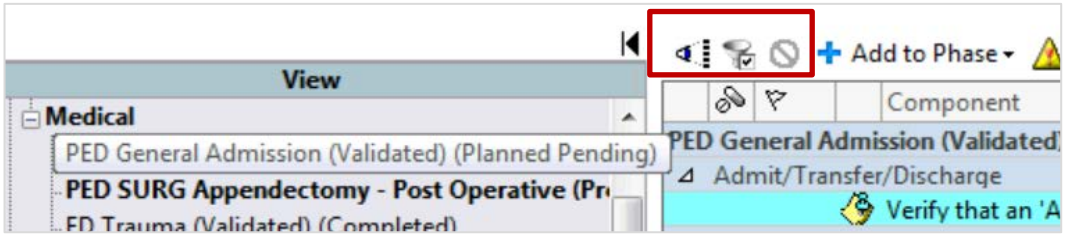


2 Click toolbar icons to flex the display of the PowerPlan to facilitate easier review. For example:

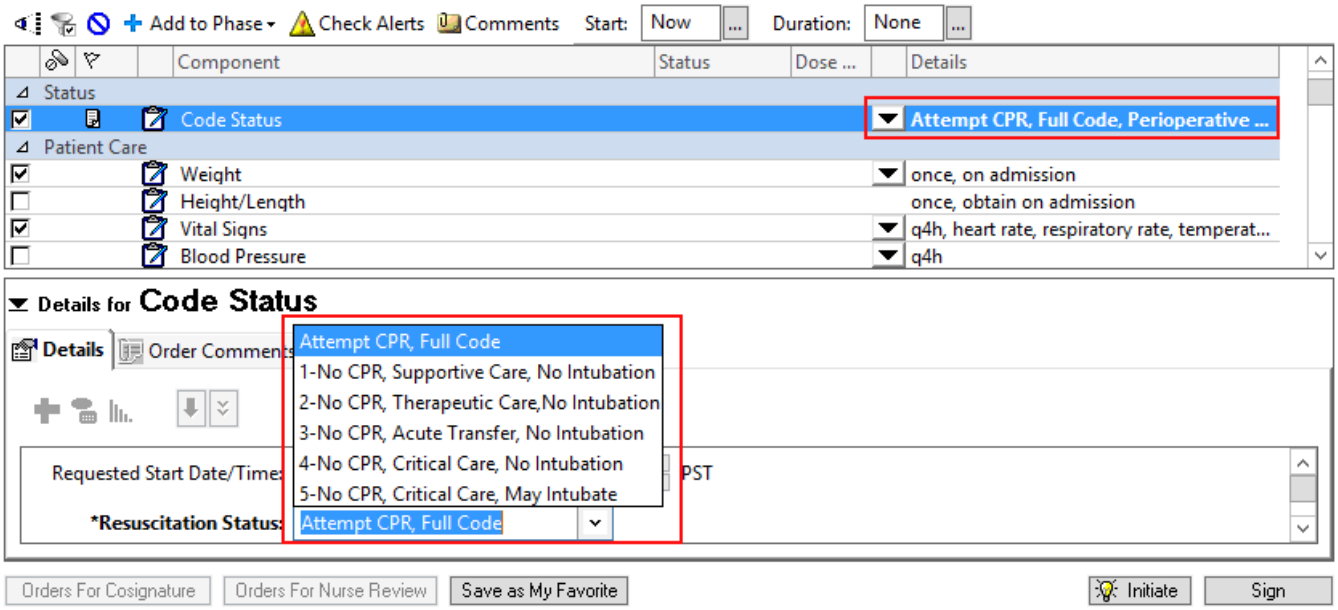
Collapses or expands the list of order categories on the left side of the screen. Collapsing the list creates more room for the PowerPlan Navigator

Merges your planned orders with existing orders to avoid duplicating an order. However, the CIS will warn about an attempted duplicate.

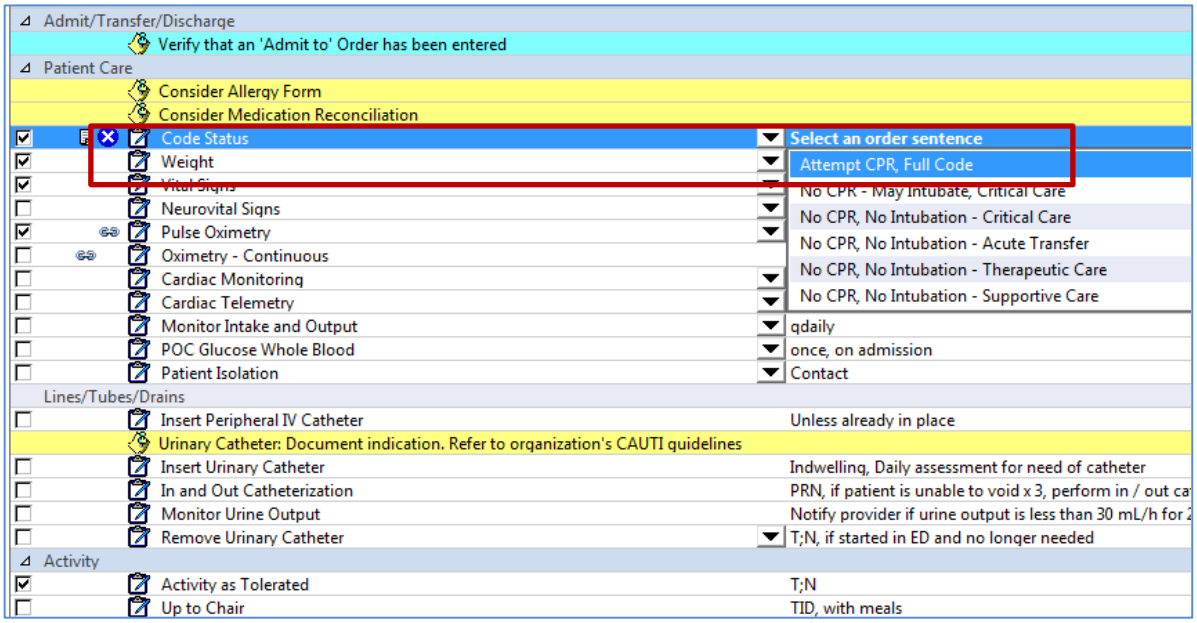
Displays pre-selected defaulted orders only



3 **Code Status** is pre-selected as Full Code but the order sentence can be updated by double clicking the order to select a new option.



Note: The icon next to the order indicates missing details. This is a standard icon across the CIS. Clicking the icon displays the screen with clinical decision support information.

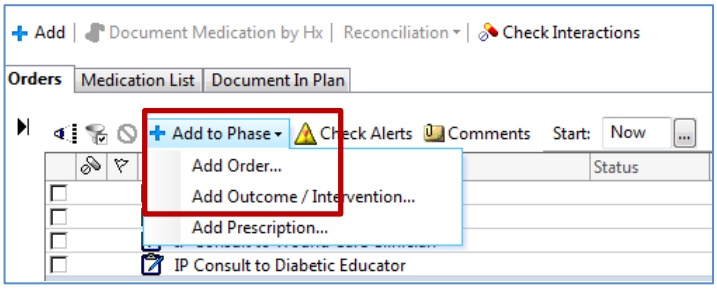


4 Continue adding the following orders to the PowerPlan. Remember to click the button to expand or collapse the order details view.

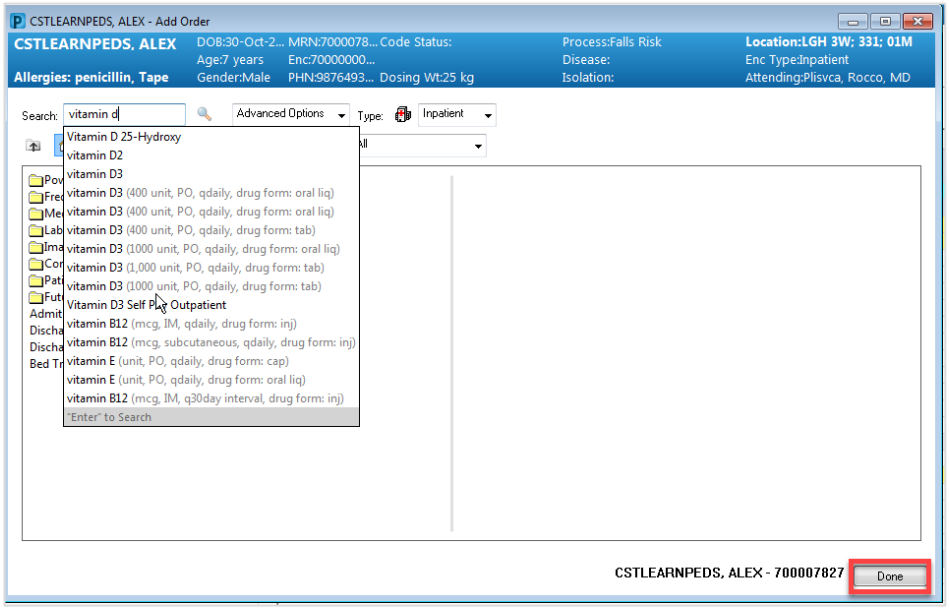
- Monitor Intake and Output
- General Diet Pediatrics (4-8 years regular, clinically indicated)
  (**Note:** Only one type of Diet Order can be entered at a time for your patient. Both orders are marked by the link icon. In this example it prevents two contradicting orders to be placed at the same time. In other situations, orders might be linked so that they can automatically be placed together.)
- Basic Metabolic Panel
- IP Consult to Physiotherapy (fill in "Reason for Consult")

Note: You can select details provided by the order sentence or change details manually in the Details view.

5 You want to add some orders that are not part of the PowerPlan. Click **+ Add to Phase** button.



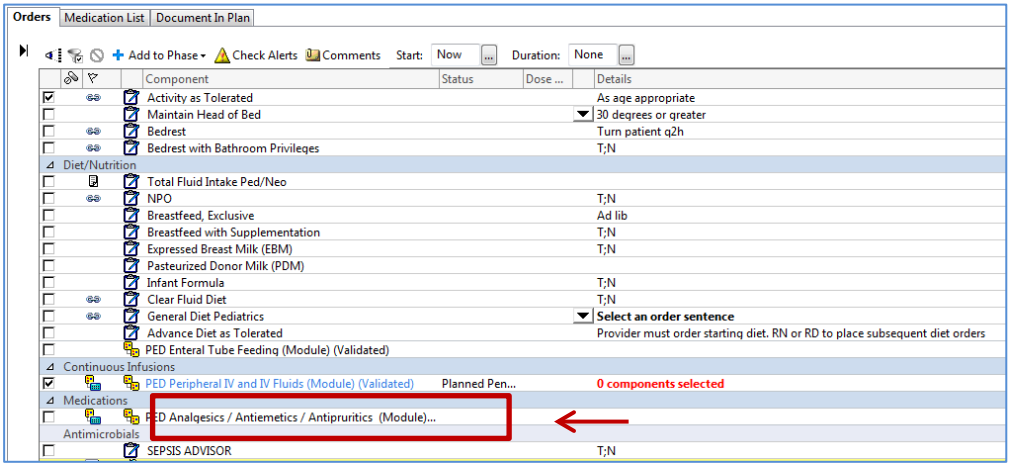
6 The Search window displays. Search the order catalogue for Vitamin D3 400 IU PO daily then click **Done**.



7 You will see these orders in the Plan Navigator added under the appropriate order categories, in this case, **Medications**.

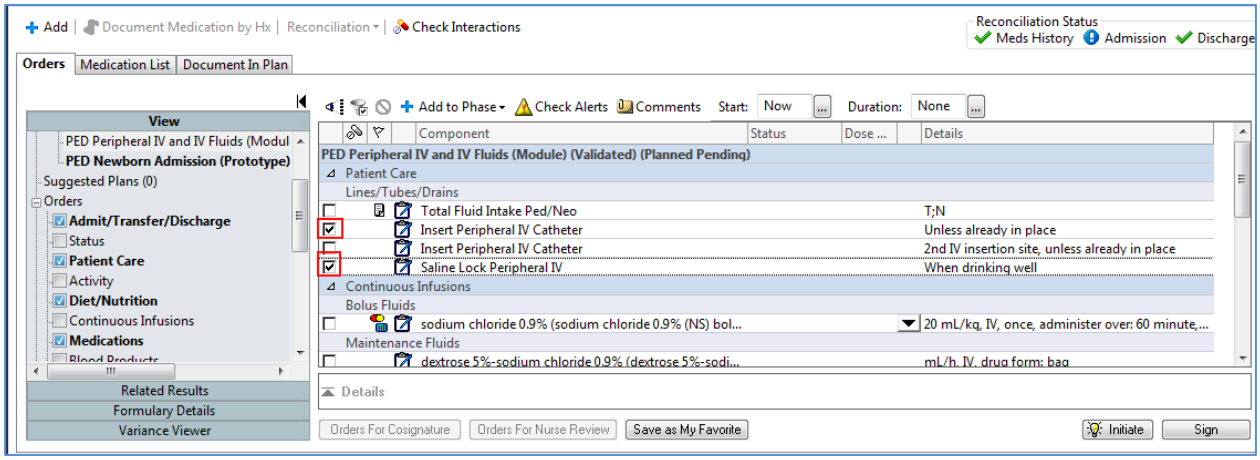
Selecting Additional Module

1 Scroll down to locate the **PED Peripheral IV and IV Fluids (Module)** and click the box beside it.

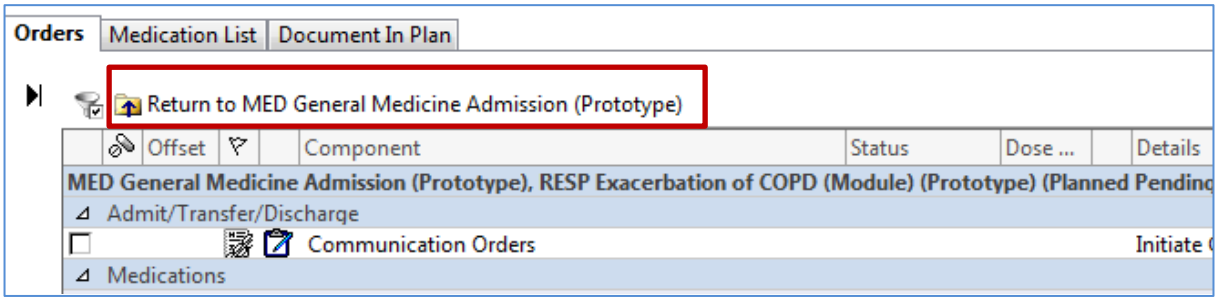


2 The list of module orders displays. Select the following:

- Lines/Tubes/Drains: **Insert Peripheral IV Catheter**, unless already in place
- Lines/Tubes/Drains: **Saline Lock Peripheral IV**, when drinking well
- Maintenance Fluids: **Sodium Chloride 0.9% continuous infusion**

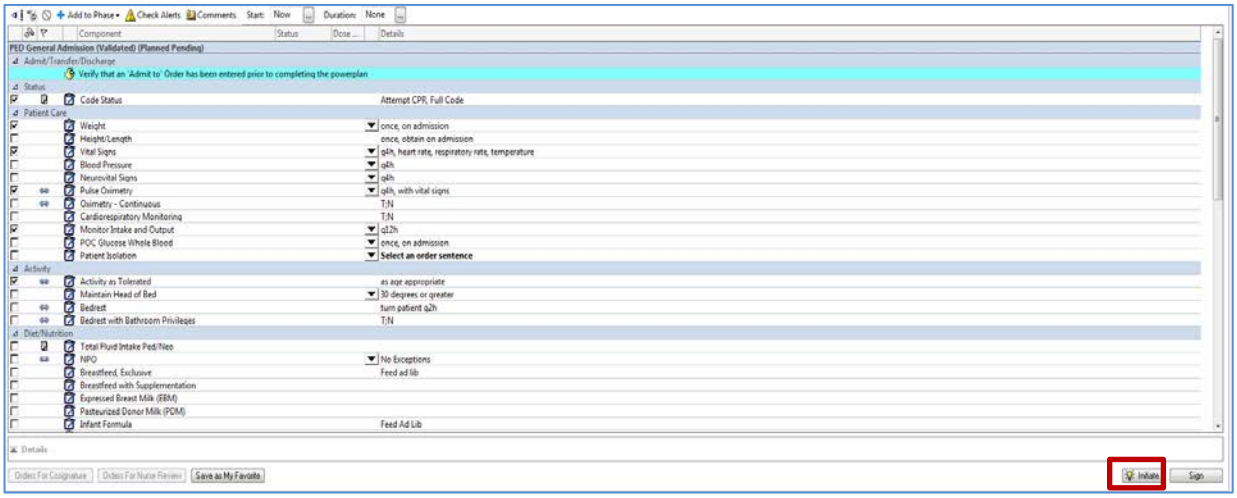


3 Once you have made your selections for this module, **do not** sign yet. You need to return to the main PowerPlan by selecting **Return to PED General Medicine Admission** to sign off the entire PowerPlan.



4 Now, all your orders are selected and you are ready to sign off. Remember to use to see what has been selected so far and to merge your plan with other current orders. This will help to identify any duplication.

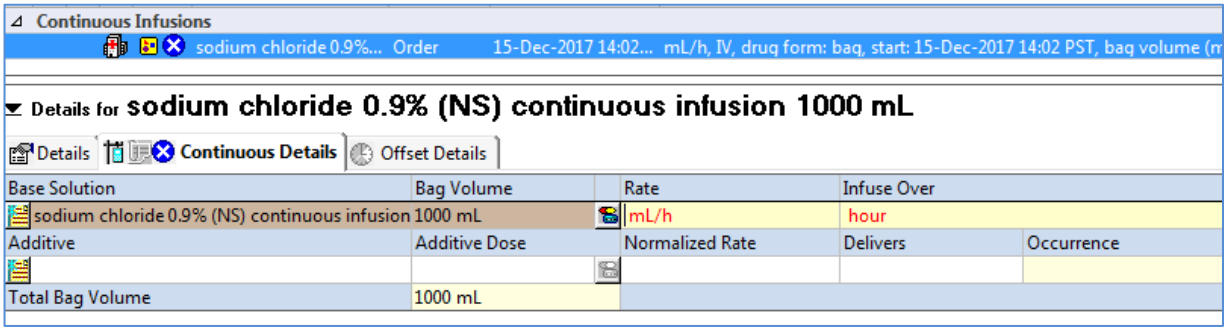
For this patient, **Initiate** the plan.

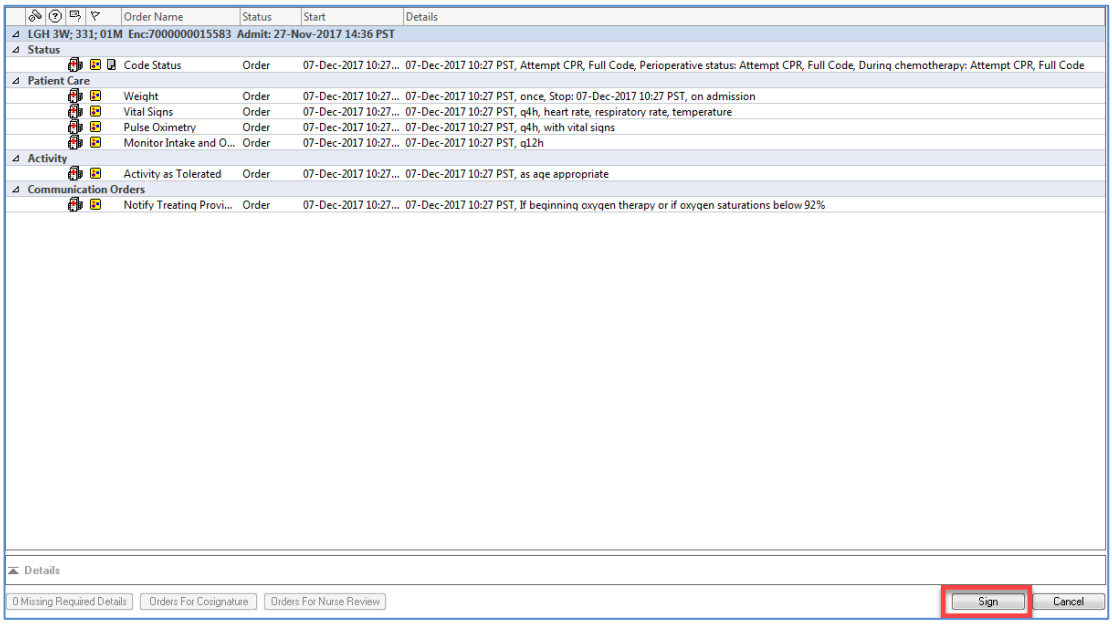


Note: Click **Initiate** first to ensure that all selected orders are immediately active. If you **do not** initiate the PowerPlan and click **Sign** only, the orders are **not** active. The PowerPlan will instead remain in planned state until it is activated later by a provider or a nurse assigned to this patient. For example, you could place the PED General Admission PowerPlan in a planned state while the patient is still in ED. The receiving nurse can then initiate the PowerPlan order upon patient's arrival on the Pediatric Medicine unit, and the orders will then become active.

5

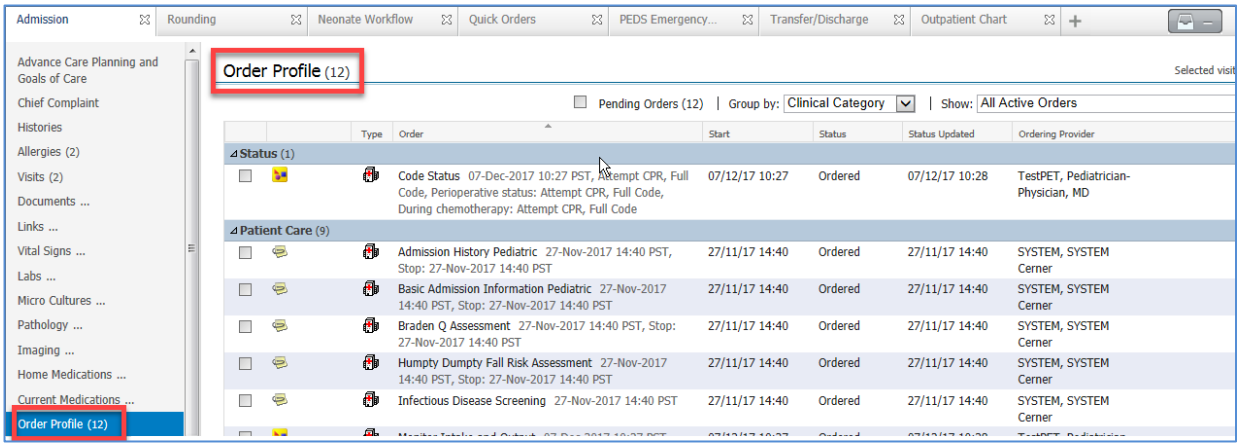
Once **Initiate** is selected, the Plan Navigator displays only your selected orders.
Click **Sign** to complete the process. Your orders will become active and all related tasks for your patient's care will be created for the appropriate clinician. If you have missed any details, you will be asked to complete the missing details prior to finalizing. Set the normal saline infusion to 30 ml/hr then **Sign**.





Note: If you click Cancel at this point, no orders will be placed and actioned.

6 Navigate back to the Admission tab and click the **Order Profile** component. The order profile allows you to review all currently active orders for the patient. This view lists individual orders. The icon indicates that the order is part of the PowerPlan.



Note: PowerPlans that are in a planned status – signed but not initiated – are not listed under Orders Profile. Click on the **Order Profile** heading to review orders including those in planned stage.

Key Learning Points

- PowerPlans are similar to pre-printed orders.
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality.
- You can select from available order sentences using drop-down lists or modify details manually where needed.
- Initiate and Sign (2 step process) means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals.
- Sign will place orders into a planned state for future activation.

Activity 1.5 – Document Your Subjective/Objective Findings and Add Admission Diagnosis

Now that you have entered your admission orders, you are ready to continue updating the chart. The next components are:

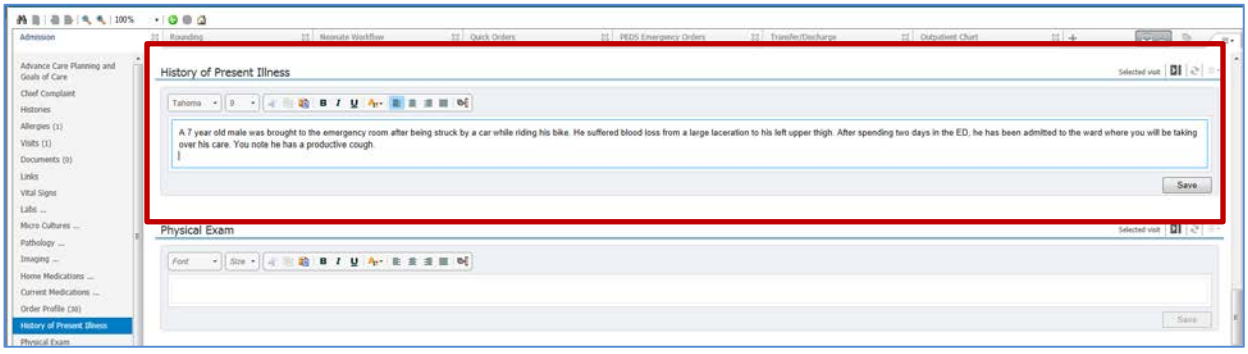
1. History of Present Illness
2. Physical Exam
3. Assessment and Plan

The above components are **free text** components where you can type or dictate. Front end speech recognition (FESR) software captures your dictation directly into the Clinical Information System (CIS).

They serve as a temporary note pad where you may enter your notes without leaving the Admission tab. Information entered here is saved until you are ready to create a formal Admission note. With one click, this information will be transferred into the note. Until then, any information captured will only be visible to you.

The other type of data entry requires selecting information from lists or catalogues pre-defined in the CIS. This entry type improves data quality and can be used to generate reports.

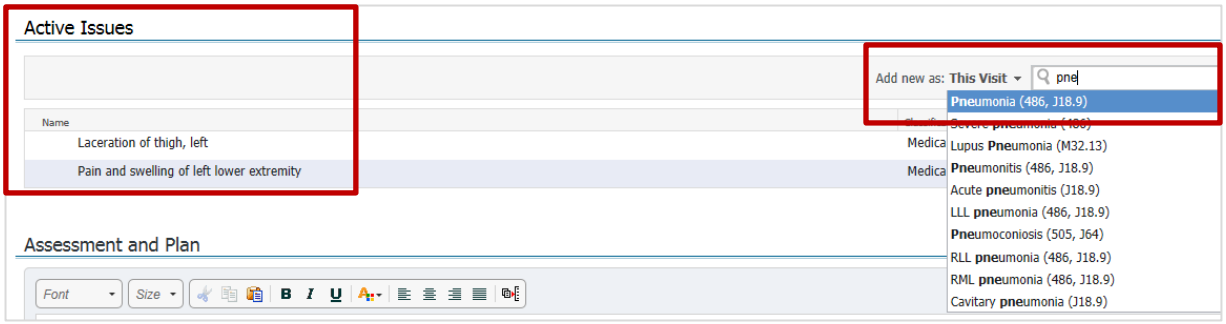
1 Click the blank space under **History of Present Illness** to activate the free text box and type some text.
For example:
“An 8 year old male was brought to the emergency room with shortness of breath, fever and productive cough after being unwell for several days.”



2 Continue adding your notes in the **Physical Exam** component.

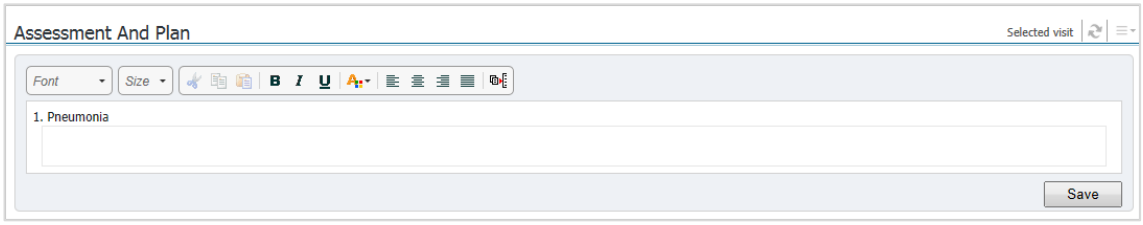
3 Select the next component, **Active Issues** capturing the patient's chronic problems and presenting issues for this visit. It pulls relevant information from patient histories e.g. problems and diagnoses. You will learn how to manage patient problems later.

Add pneumonia as an admitting diagnosis for the patient. Search for *pneumonia* and select it from the list. (The system uses medical coding languages such as ICD-10-CA and Intelligent Medical Objects (IMO) to capture problems and diagnoses.)



4 Ensure that pneumonia is listed as **This Visit (presenting)** issue.

5 Display the **Assessment and Plan** component – the pneumonia diagnosis is already listed. For our example, leave this free text box as it is. You will have an opportunity to add this information directly in a charting document.



Key Learning Points

- Your findings and observations can be added directly into appropriate free text components within the Admission workflow tab.
- Text entered in the free text components is not visible to other care team members until you create and sign your document.
- Use the Active Issues to capture both presenting issues (This Visit) and chronic issues (Chronic).

Activity 1.6 – Complete an Admission Note

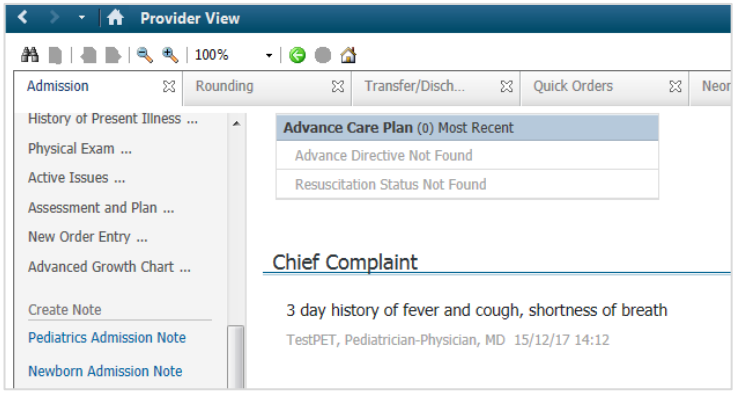
As the last step of admitting the patient, you create the admission note.

The Clinical Information System (CIS) uses **Dynamic Documentation** to pull all existing and relevant information into a comprehensive document, using a standard template.

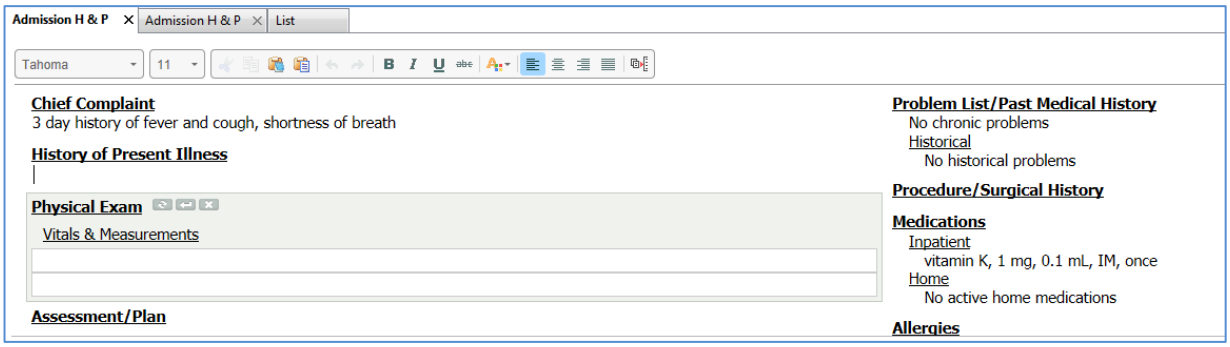
Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why **it is more efficient to create the note as the last step** of the admission process. You can also add new information directly in the note by typing or dictating.

Workflows such as Admission, Rounding, and Transfer/Discharge have the **Create Note** section. Clicking on these items displays the relevant note types represented by links to make documentation easier. With one click on the desired note type link, the CIS generates a charting note.

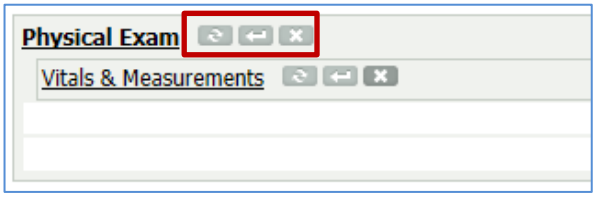
1 Navigate to the **Create Note** section and click **Pediatric Admission Note**.



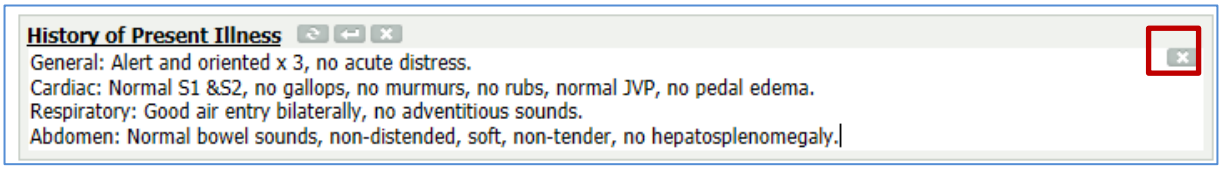
2 The draft note displays in edit mode.
It is populated with the information captured by you and other clinicians saving you time.
Review different sections of this note in both columns.



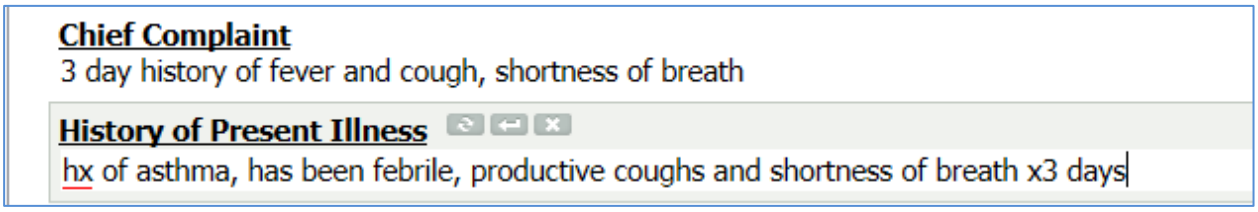
3 You can remove a section that is not required or is currently blank. For example, place the cursor over the heading and click on the toolbar to remove the entire section.



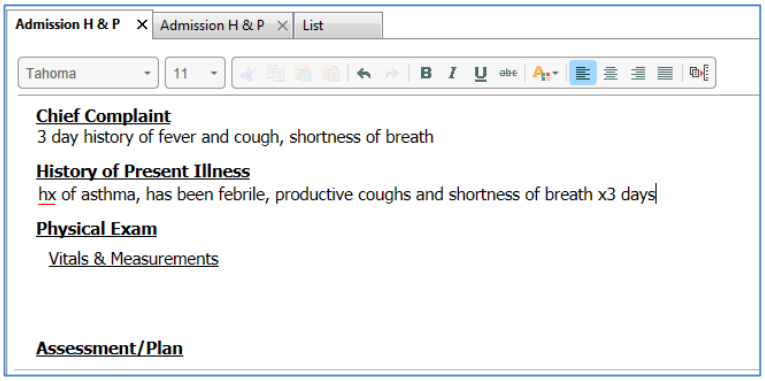
4 You can remove the entire content of a section. For example, place the cursor over the heading and click the in the text box.



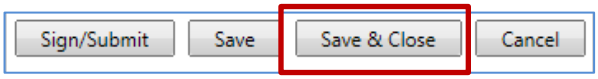
5 You can also edit the existing text. Place the cursor over the heading to activate the text box. When the box becomes active, select the text to add or delete as needed.



6 Review the **Assessment/Plan** section. It is populated with the diagnosis you have entered. Enter new text to practice.



7 To complete your note, click **Sign/Submit.**



Note: You have also an option to click Save or Save & Close to continue to work on this document later. Saved documents are not visible to other care team members until **Signed**.

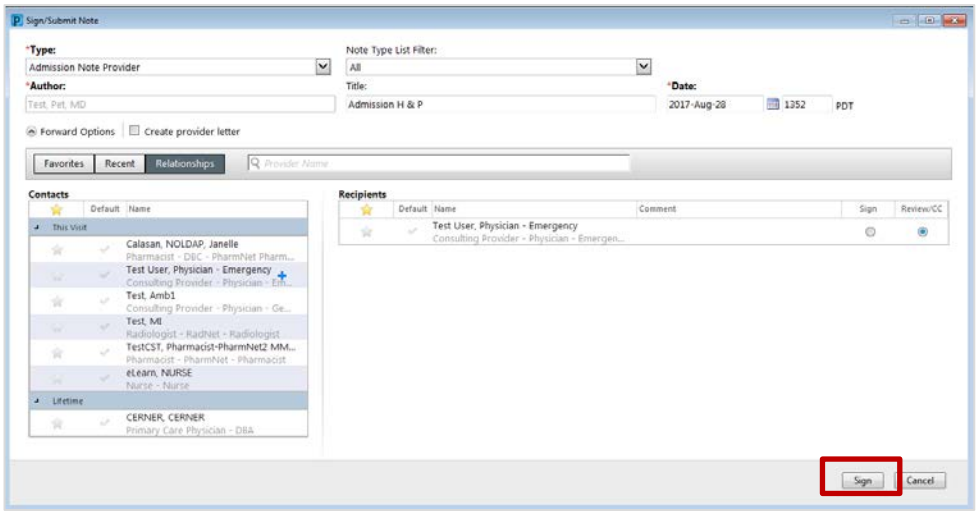
8 In the **Sign/Submit window**, typically no changes are required if you use the link to create your document.

Note **Type** and **Title** are already populated but you can edit the **Title** to potentially make future searching easier.

You will learn later how to use the **Forward** option to send copies of the admission note to other providers.

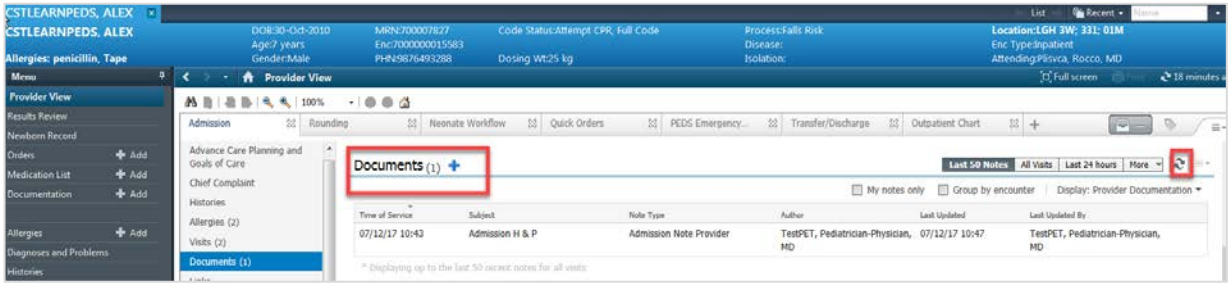
The **Date** box auto-populates with the current date. Ensure that it indicates the date of patient's admission, not the date the note is created.

Click **Sign** to complete the process.



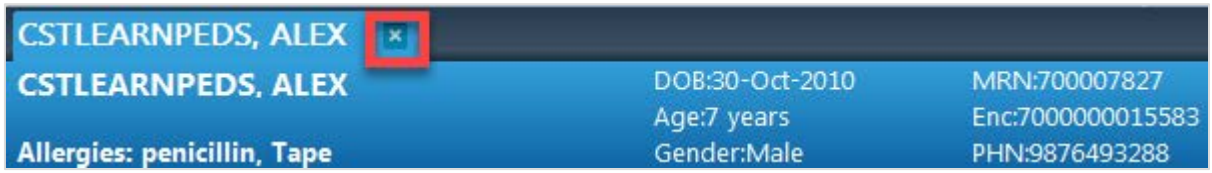
9 Once the note is signed, it cannot be edited. Any change requires creating an addendum. You will practice adding an addendum later.

After signing the note, you are transferred back to the Admission tab. Remember to click the **Refresh** button on the Documents component. The admission note is now listed and is visible to the entire care team.



10 To close this patient chart, you would click the x icon on the Banner Bar.

***For the purpose of this session, please do not close out of this patient's chart yet.**



Key Learning Points

- Using Dynamic Documentation to prepare notes standardizes documentation practices.
- Use note links listed under the Create Note sections to produce documents efficiently.
- Only when a note is signed and submitted will it be visible to the rest of the care team.
- Saved notes remain in a draft format and are visible only to you.
- Once you sign and submit a note, further edits can be added but will appear as addenda.

PATIENT SCENARIO 2 – Managing Your Patient during Rounding

Learning Objectives

At the end of this Scenario, you will be able to:

- Update patient information.
- Modify current orders.
- Review documents and create a progress note.

SCENARIO

Continuing with the same patient, it is now the next day. The patient was admitted yesterday with fever and productive cough. The patient has remained febrile and lethargic.

You round on your patients and examine this child. The patient is stable but you want to continue antibiotics.

You will complete the following 6 activities:

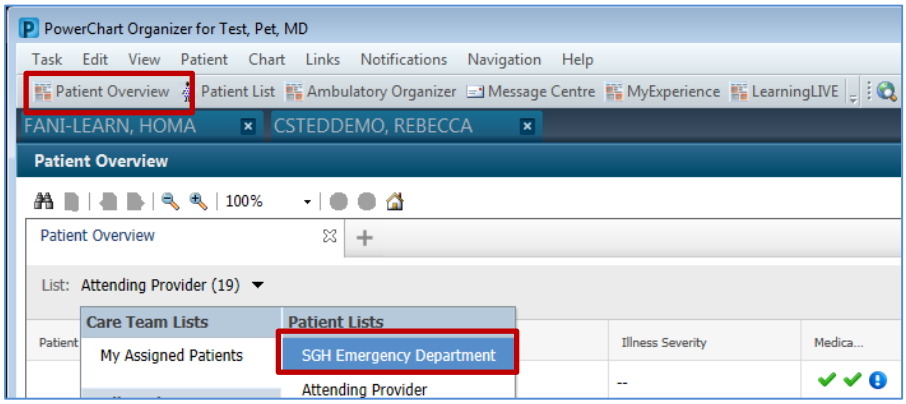
- Review and update patient history.
- Review and update patient allergies.
- Review documents, labs, and imaging.
- Manage orders – add, modify, and cancel.
- Update Active Issues.
- Complete a progress note.

Activity 2.1 – Review Histories

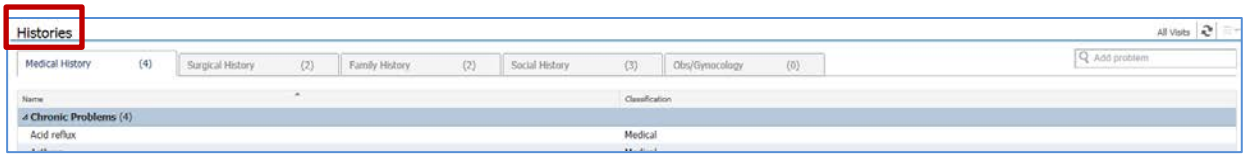
Notice that some components have a status line. If a patient has returned to hospital and you review their chart for the first time, review their histories information and document the reconciliation status as complete. For a component with **Incomplete** status, update the information if necessary.

The patient just told you about having his tonsils removed last year. If a patient had a surgical procedure in the past that has been documented in the CIS, this record will display automatically under the Surgical History. Let's document this under **Surgical History**.

1 Click **Patient Overview** on the top toolbar and select the appropriate list, in this case **pediatrics.**

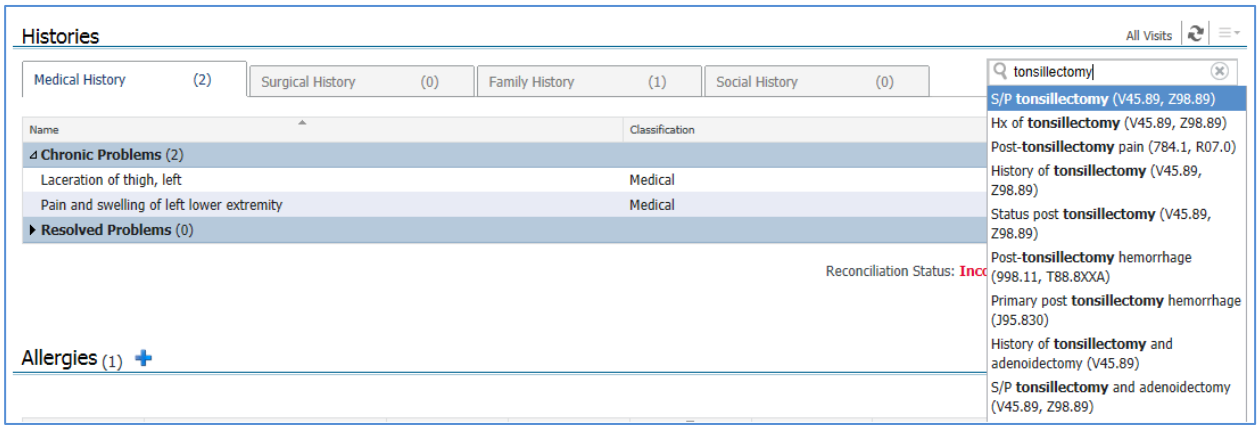


2 Click on the patient's name to open his chart. Ensure you are in the **Admission** tab. Scroll down to the **Histories** component.

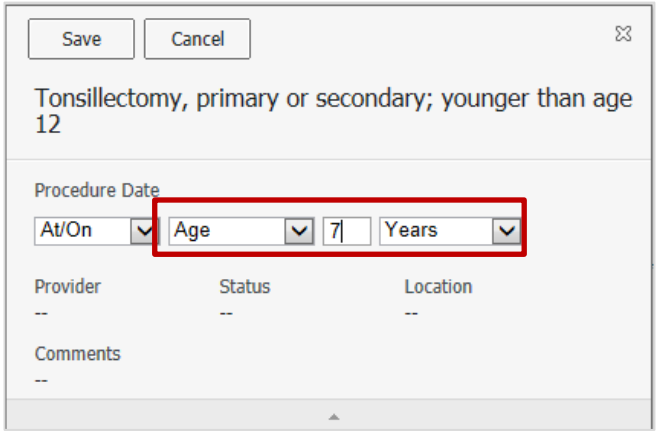


Note: There is a separate tab for each history type. The number in brackets indicates how many entries are in each tab.

3 Select **Surgical History** to add a new entry, click into the search box and type *tonsillectomy.* A list of options will appear. Select an appropriate option.



4 Enter procedure date information of *Age 7 years* and click **Save.**



Note: To review other history entries, click the appropriate tabs. To update the information, click the component heading **Histories**.

You can learn more about the specific history records from the Reference Book.

Key Learning Points

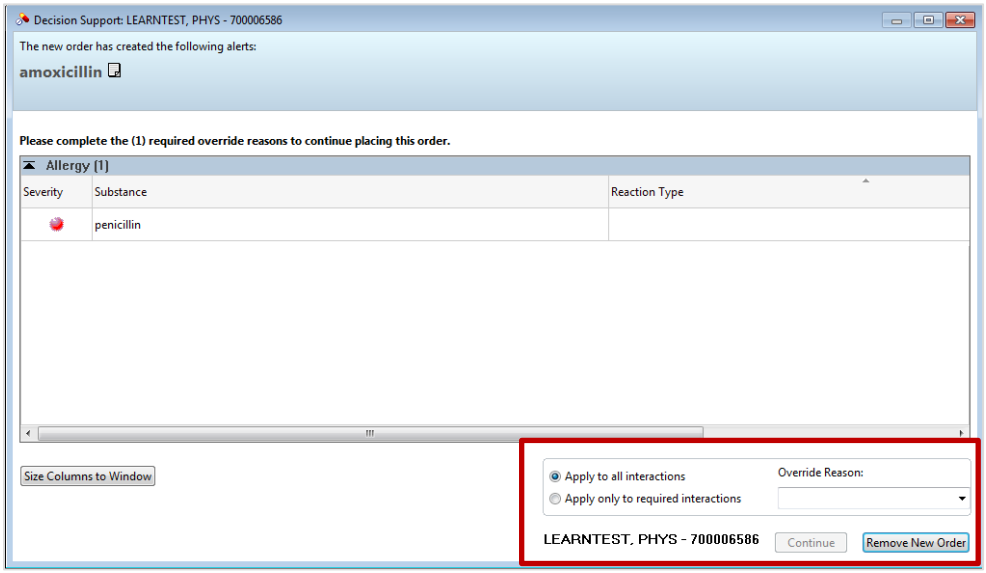
- Histories information including surgical procedures can be added when taking a patient's history.

Activity 2.2 – Review Allergies

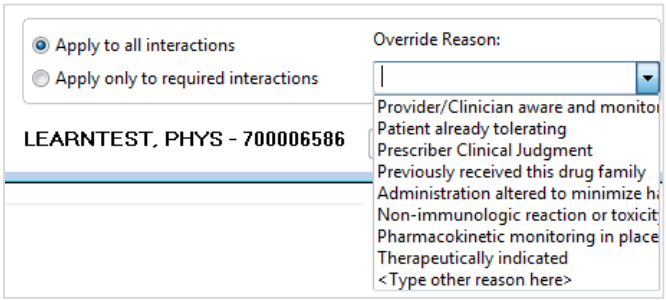
Now you review this patient's allergies and add an allergy to morphine. This information was provided by the patient's mother after admission.

In the Clinical Information System (CIS), patient allergies can be added and updated by providers and clinicians. In the inpatient setting, a patient's allergies are to be reviewed by a provider on admission, at every transition of care. Allergy information is carried forward from one patient visit to the next.

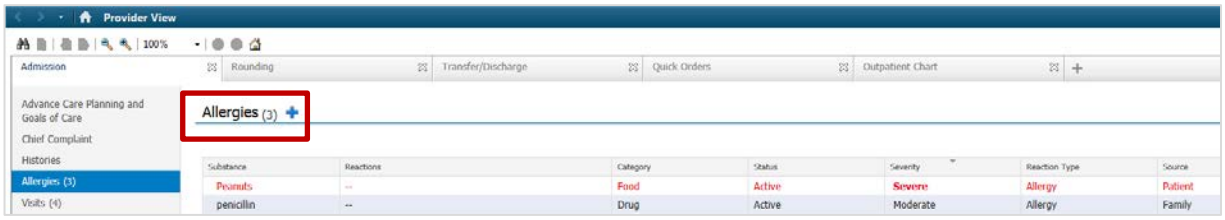
The CIS keeps track of the allergy status and will automatically prompt you when the information is not up-to-date. It will also track allergy-to-drug interactions. When placing an order with allergy contradiction, an alert will display.



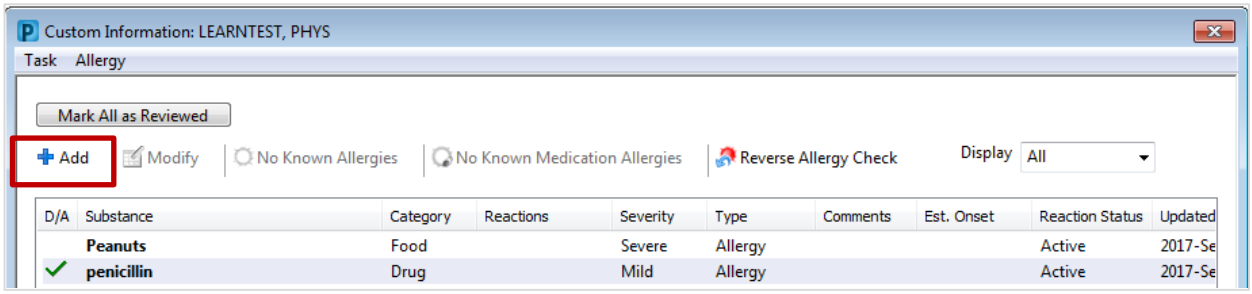
You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:



1 Click the **Allergy** link to add the morphine allergy to your patient's record

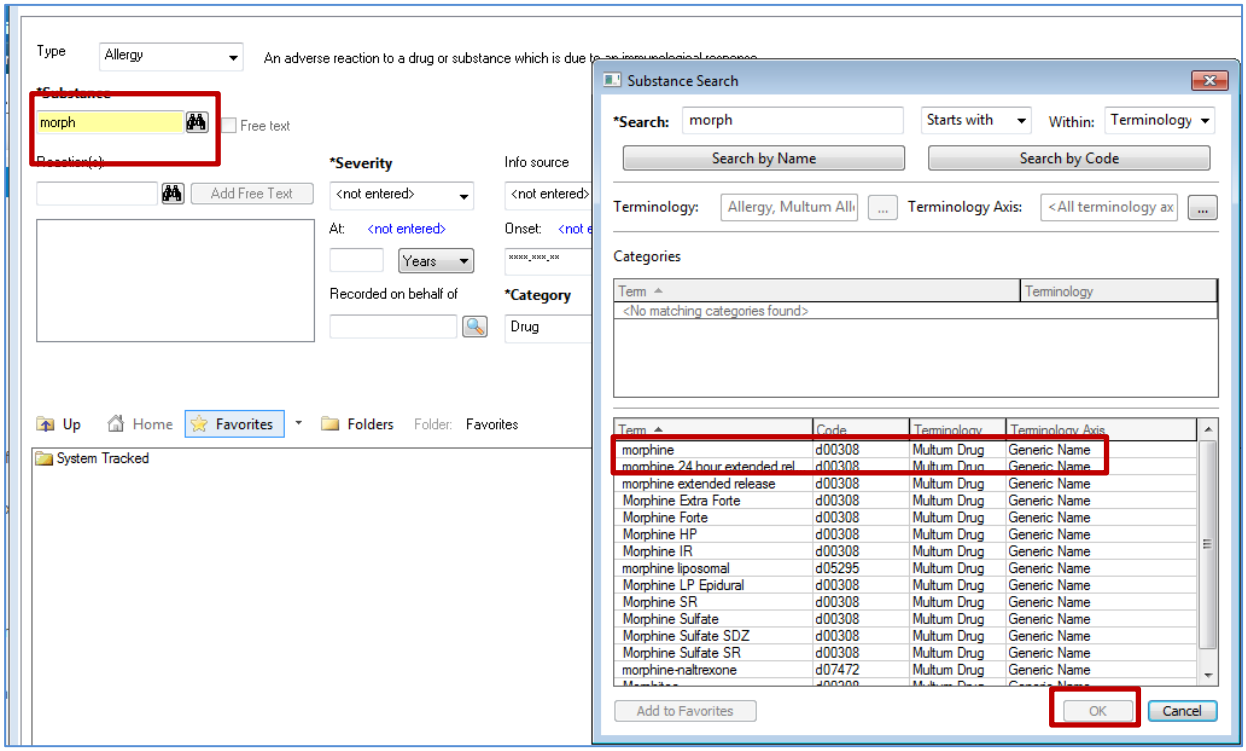


2 Click the Add icon on the toolbar.



3 Search for morphine in the **Substance** box. Remember to use to execute the search, and then select one of the options from the list.

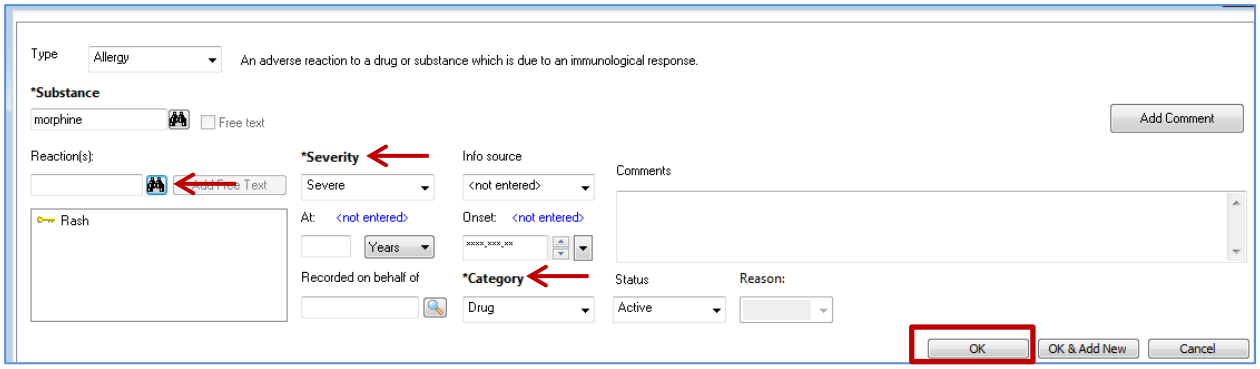
Click **OK** to return to the Add Allergy/Adverse Effect window.



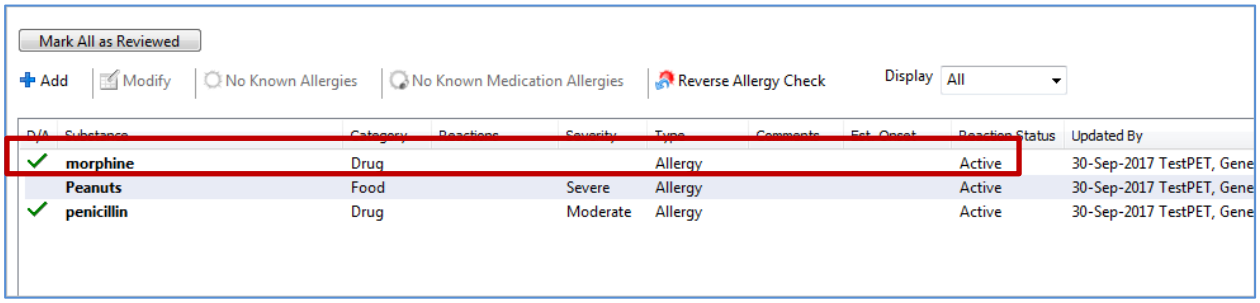
4 Add appropriate options in the other two mandatory fields:

Mandatory	Non mandatory
Select *Severe* for the **Severity**	Search for *Rash* in the **Reaction**(s) box (recommended)
Select *Drug* for the **Category**	

Click **OK** to save the information.



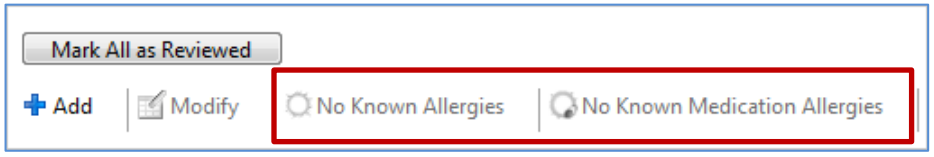
5 Patient's allergy record is updated. The green checkmark next to morphine indicates drug allergies.



6 Click **Mark All as Reviewed** to complete the review.

Note: In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. When there is no information available, you can use other the toolbar options:

- No Known Allergies
- No Known Medication Allergies



NOTE: If a substance that the patient is allergic to can't be found in the substance search, a free-text allergy must be entered. Only pharmacists can enter free-text allergies. To request that a pharmacist document this free-text allergy, please submit a consult to pharmacy be ordering "IP Consult to Pharmacy – Determine Allergy History" in the details section indicate the substance that must be entered as free-text.

Key Learning Points

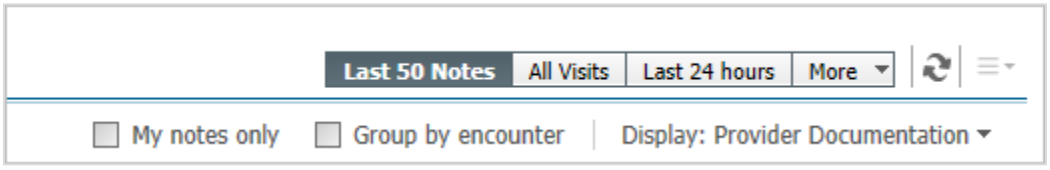
- Patient **allergies** and interactions are monitored by the CIS.
- Allergy record needs to be reviewed for each encounter on admission, at discharge, with a change in level of care.
- Review of allergies is complete when Mark All as Reviewed is selected.

Activity 2.3 – Review Documents, Labs, and Imaging

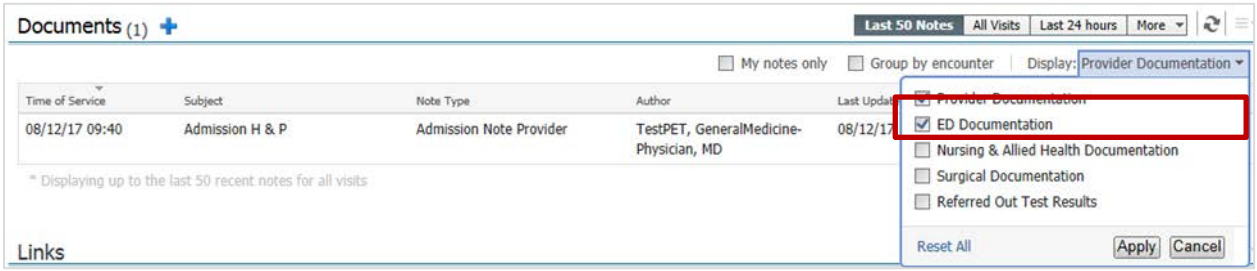
Continue reviewing the patient's chart by following the Rounding tab list of components. When using the Clinical Information System (CIS), you might be faced with large amount of information.

For many components, you can filter documents in many ways. For example, in the Documents component, you can:

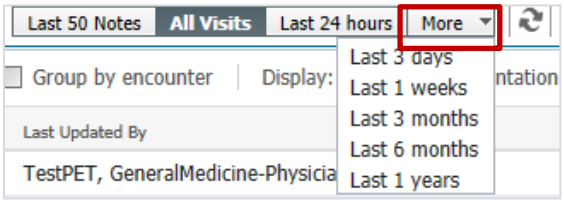
1. Display notes from the **Last 24 hours** or **My notes only**
2. Use **Group by encounter** to see notes for the current encounter only
3. Limit documents to **Last 50 notes**
4. Access notes for **All Visits**



You can display notes by a specialty, for example check only **Surgical Documentation** or to display **ED Documentation** only.



You can select a custom time range by expanding options under **More**.

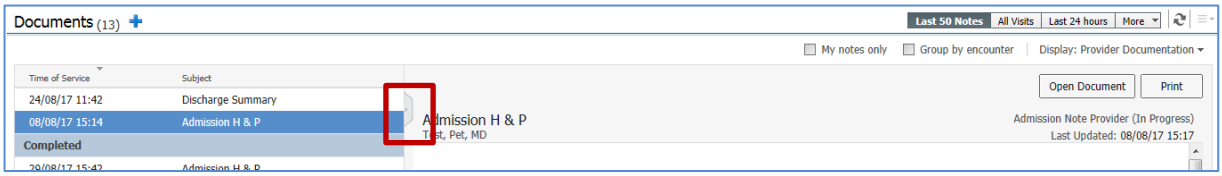


Remember that if you select a specific filter, the selection narrows and you might not display all relevant information. Ensure that the filter type corresponds with your current needs.

1 Click **Documents** to display a list of documents.

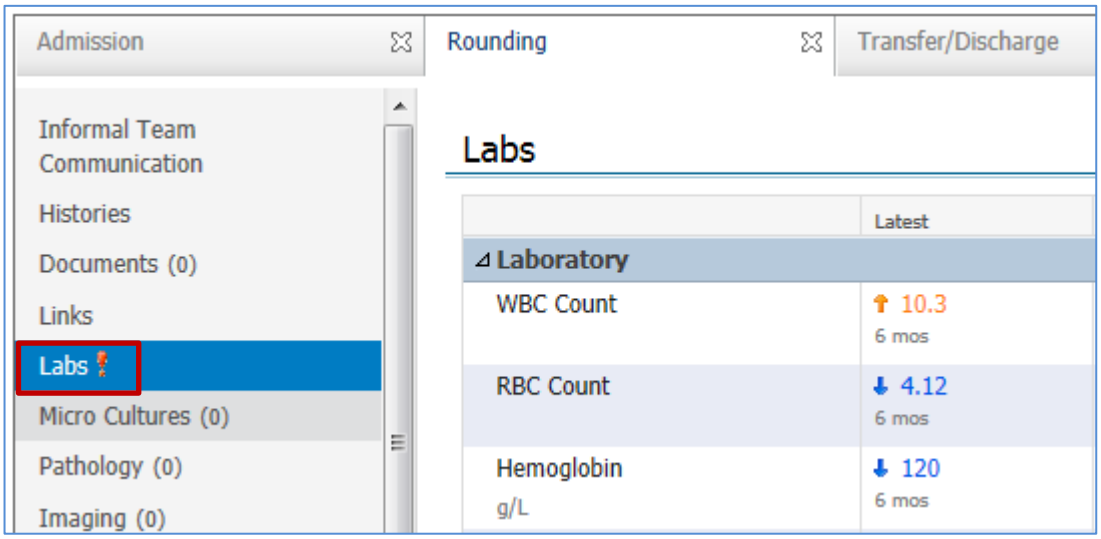
Select the document line to display the content of the document without leaving the screen. Clicking tab closes the split screen.

Click the tab to remove the split screen.



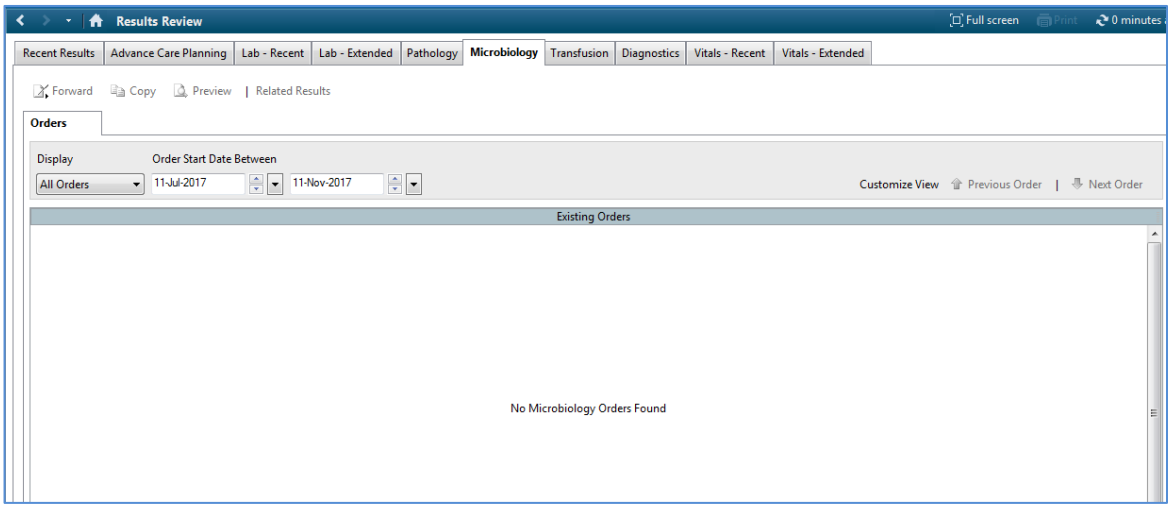
2 For labs and other diagnostics – use filters to display results that are relevant to you. You can click on individual results to get more information such as critical highs/lows.

Note: Clicking the refresh icon on this individual component will update the information just for this component.



Remember to hover to discover more information about the lab result.

3 Click the **Labs** component header to go to **Results Review** to display comprehensive summaries of patient's results grouped into separate tabs.



What is this view called?

Use the navigation buttons  to return to the Provider View.

Key Learning Points

- Using filters will display only pertinent information.
- Remember to check what filter is currently selected to ensure that it fits your current needs.

Activity 2.4 – Manage Orders – Add, Modify, and Cancel

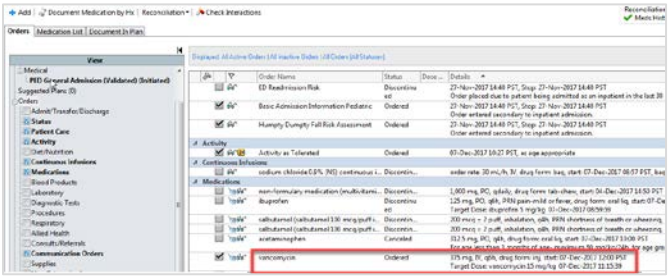
You have learned how to review and update information for your patient. One of the most important tasks is to manage orders and medications. This includes assessing, adjusting, and checking for duplicates and outdated orders.

Your next step is to review the patient's current medications and orders and make necessary modifications. In this activity, you will:

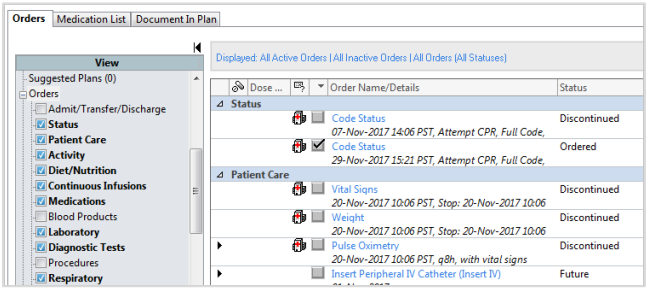
- Add orders for **electrolyte panel** and **chest x-ray**
- Modify medication order for **Vancomycin**
- Cancel order for **Acetaminophen**
- Update problems for the patient and add probable Pneumonia.

When using Clinical Information System (CIS), there are recommended practices for managing medications. When replacing a medication order with another or altering medication dosages you should discontinue the current order and place a new one. The only exception is adjusting the rate of a continuous infusion order. In this case you can modify the order.

The CIS provides few tools to manage orders:



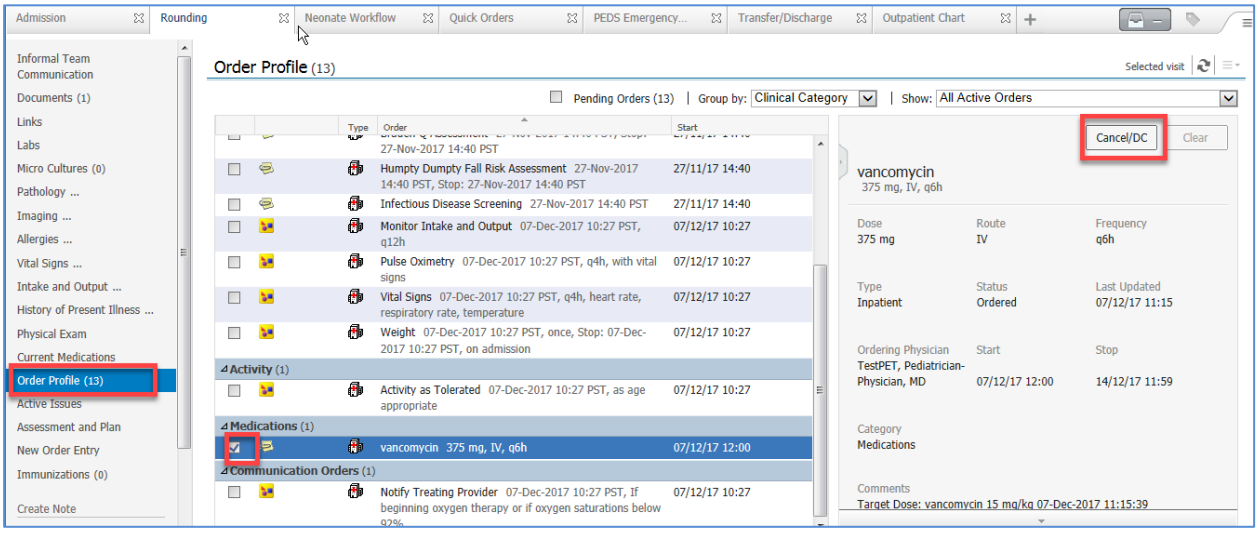
Order Profile – this view displays directly in the workflow tab. It lists all current orders.



Orders – this view displays when you click Order Profile heading. It is the most comprehensive list of orders that includes discontinued orders, PowerPlans in planned status, future orders, as well as cancelled orders.

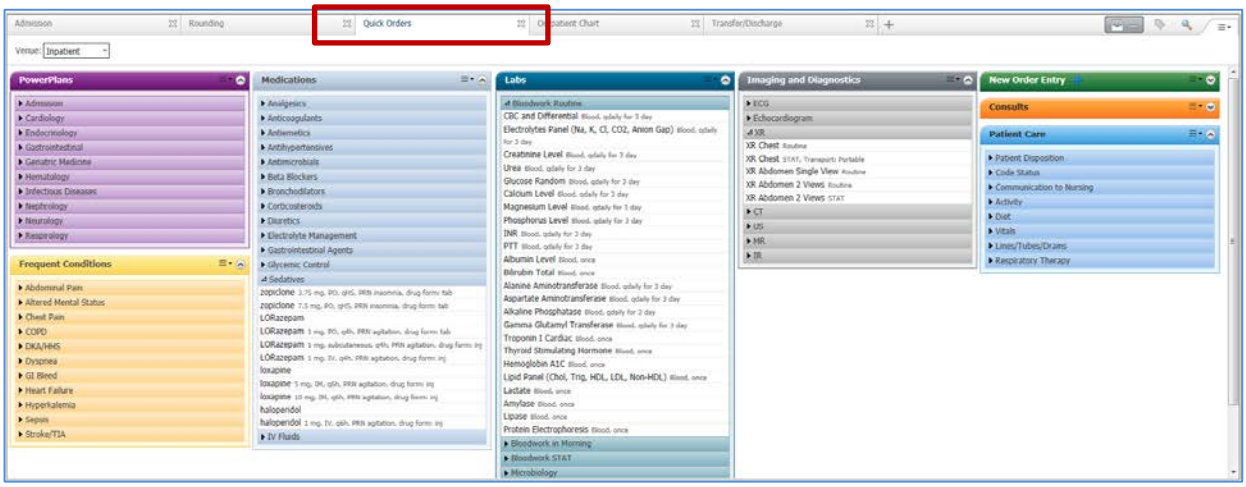
1 Now you want to change the route for vancomycin and cancel acetaminophen. First, stop the medications you want to modify.

In the Rounding tab, select **Order Profile** component and locate **vancomycin** on the list. Select the check boxes next to these medications and click **Cancel/DC**. Complete the same steps for acetaminophen.

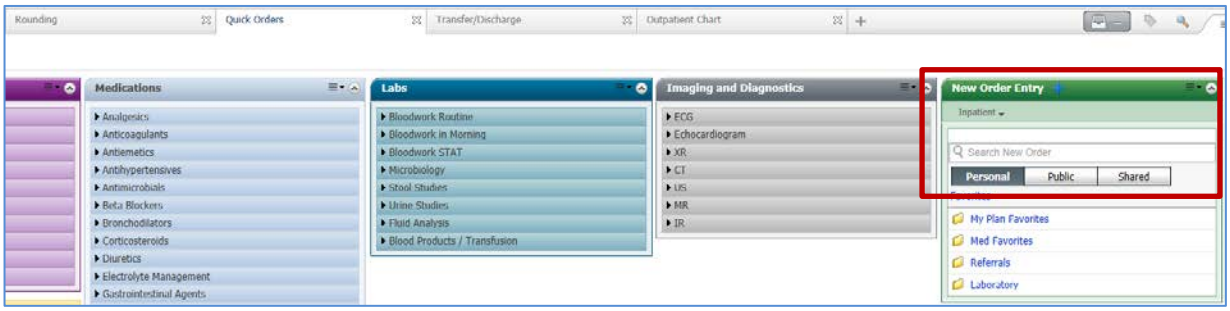


2 The second step is to place new orders. Go to your **Quick Orders** tab and select orders for:

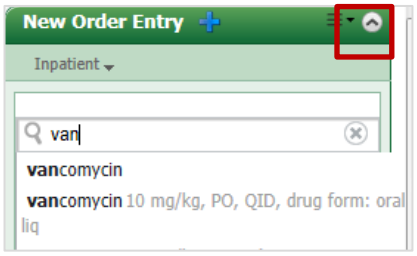
- **Electrolytes Panel-** under **Labs > Bloodwork AM**
- **XR Chest-** under **Imaging and Diagnostics > XR**
- **Vancomycin** > **New Order Entry**



3 If you cannot locate the necessary orders under your folders, expand the **New Order Entry** component.

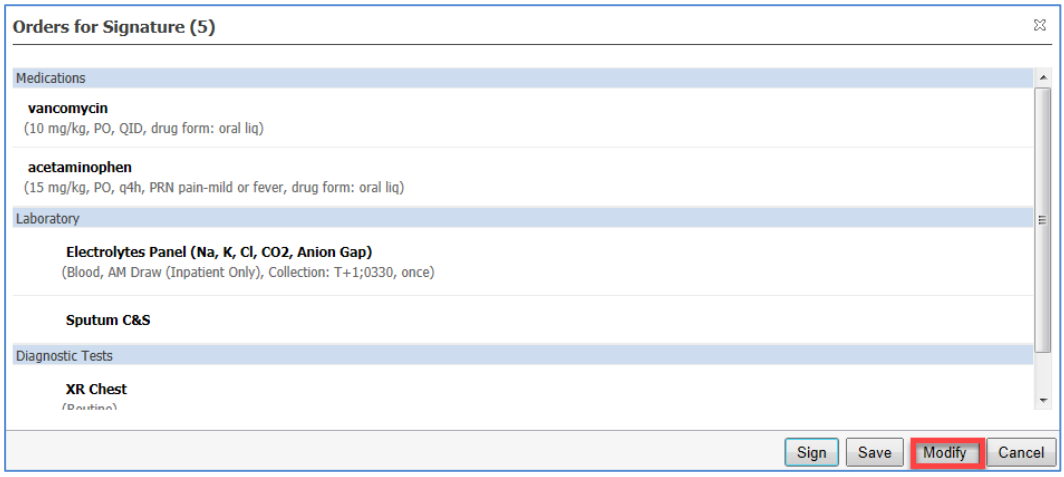


4 For **New Order Entry**, search for the order by typing the first few characters to display list of options. Adding dosage will truncate the list further and make the selection easier. **Note:** If you do not see the search box as shown below, it may be collapsed. Click the arrow to expand the search box.



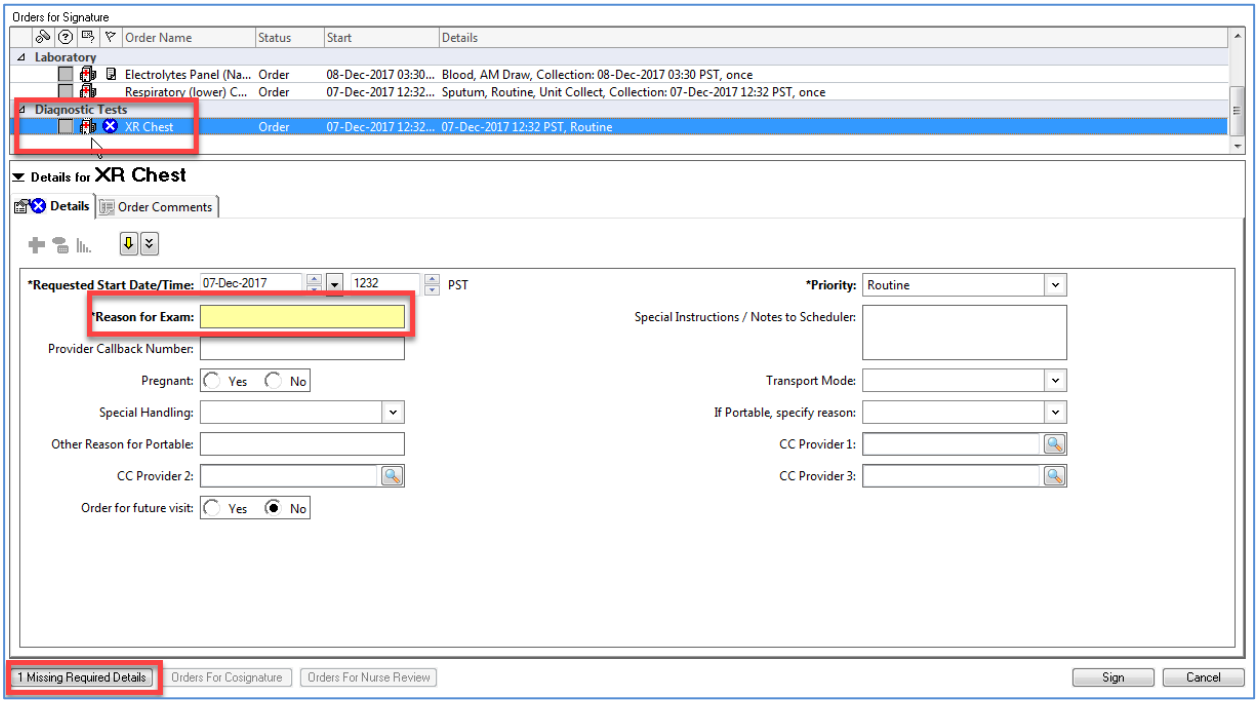
5 Once all the orders are selected, click **Orders for Signature** 

6 In the Orders for Signature box, click **Modify**.



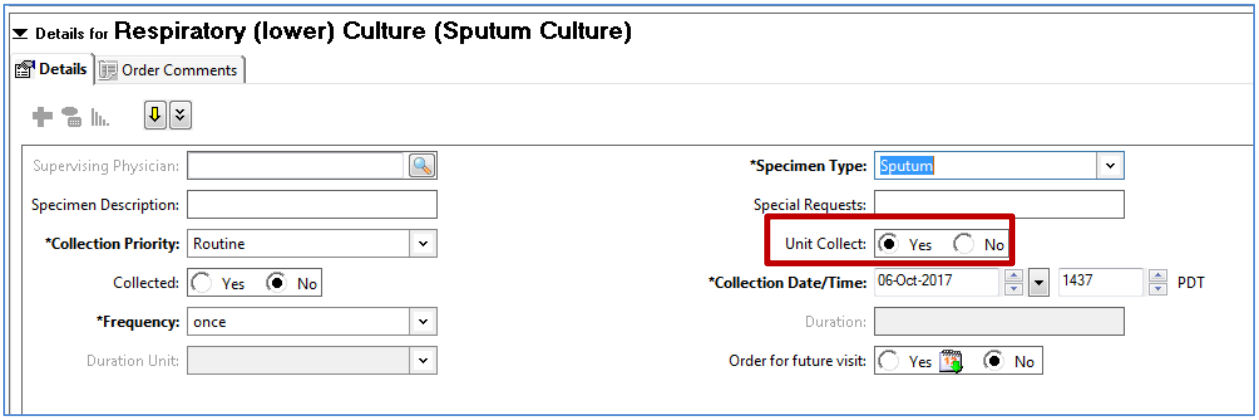
Note: When you do not want to change any details, click **Sign** to complete the process after checking that all required details are filled out.

7 You will be prompted to add missing order details that are required. In our example, you need to add the reason for the chest x-ray. **Do not click the box beside the order unless you wish it to be made as a proposal rather than order.**



8 Next, display details for the sputum culture test.

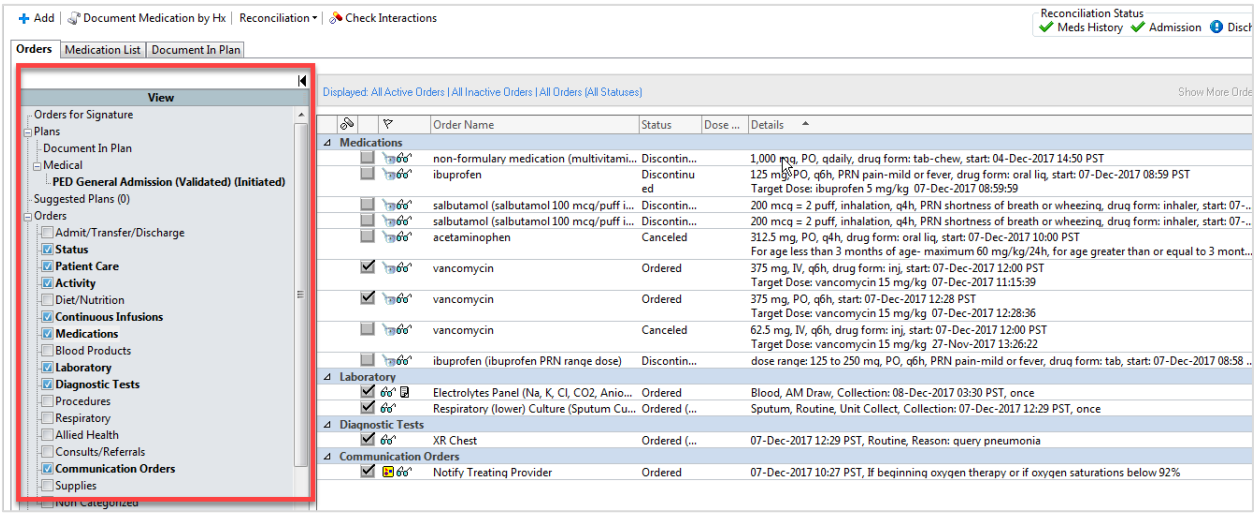
Note: For **Unit Collect**, **Yes** is preselected. This means that the unit collects the specimen and is responsible for printing the label and delivering the specimen to the lab. There is also an option to indicate if the specimen has already been collected.



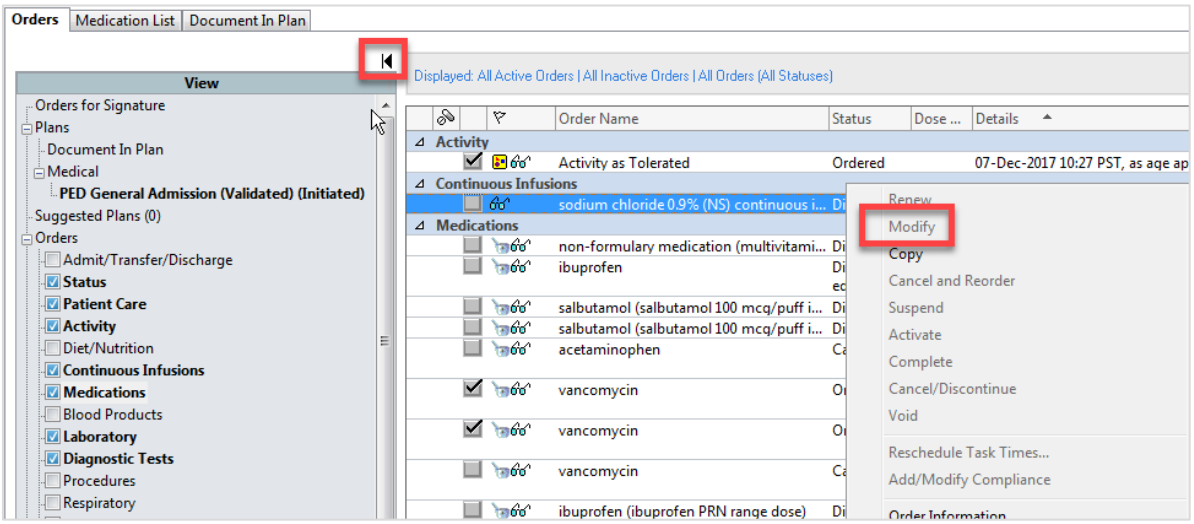
9 Click **Sign** to complete the process and return to the Provider View and Rounding tab.

10 Now, you want to modify the rate of NaCl 0.9% (NS) IV from 30 mL/h to 35 mL/h. The continuous infusion order – not like other medication orders – can be modified. It must be done from the Orders view.

Click the **Order Profile** heading to display **Orders** view. Here, orders are organized into different categories in the View navigation panel.



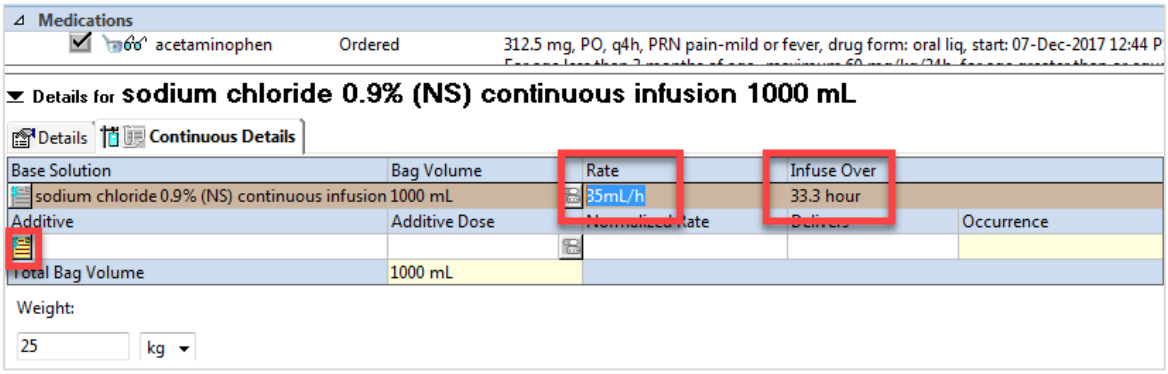
11 Locate the order under **Continuous Infusions**, and then right-click and select **Modify.**



Remember to use the arrow to collapse or expand the View navigation panel allows for more screen space.

12

1. In Details window, select the rate **30 mL/h** and type *35*.
2. Click in the cell that displays the infusion time to trigger time calculation.
3. Click **Sign** to complete the order.



Note: You can click the Additive icon to search for a medication to add to the continuous infusion order. For example you can search for potassium chloride.

13

Icons provide additional information. In the **Orders** view, hover to discover.

indicates ?

indicates ?

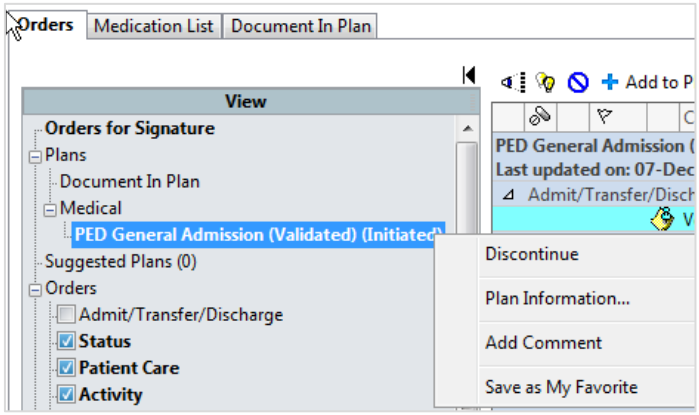
indicates ?

indicates that the order comes from a PowerPlan

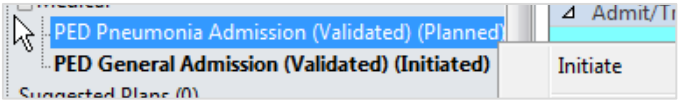
14

Advanced users can effectively manage orders from the Orders view:

Example 1: Select the PowerPlan under View and right-click to select **Discontinue** either the entire plan or individual orders.

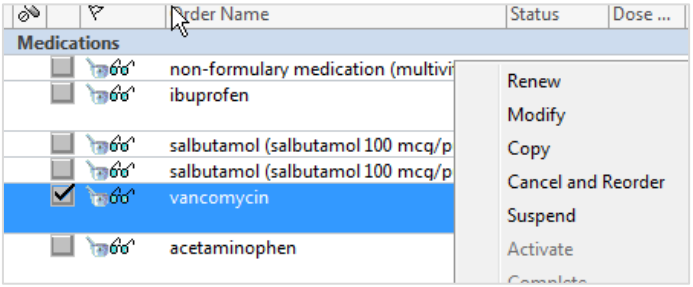


Example 2: For PowerPlan in a planned status, right-click and select **Initiate** to activate the plan you prepared earlier.



Example 3: Select an individual order from the list, right-click and select one of the available actions:

- Cancel and Reorder for example to change medication dosage or route
- Cancel/Discontinue to stop the order
- Convert to Prescription to print a prescription from the existing order



Key Learning Points

- There are many ways to place a new order. Use the method that is the most convenient for your current situation.
- To replace a medication, start by discontinuing the existing order and then place a new one.
- Only continuous infusions orders can be modified if rate has to be altered or additive added.

Activity 2.5 – Update Active Issues

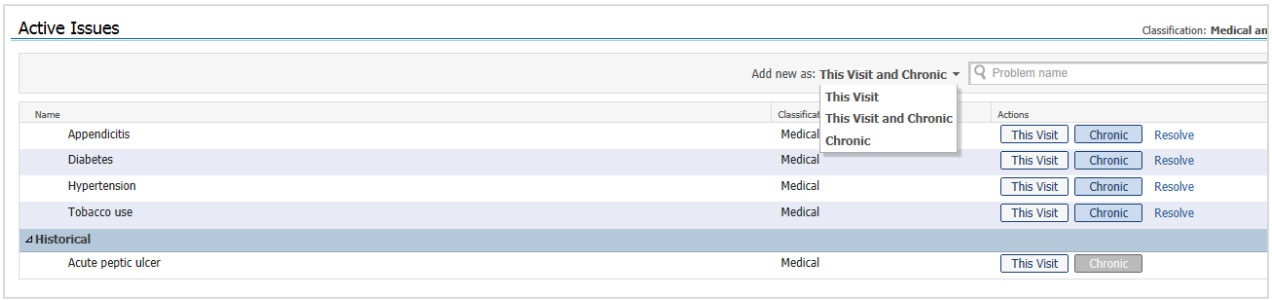
Active Issues is the next component on the Rounding tab. It is identical to the component we used for admission to add an admitting diagnosis. Now you will document chronic shortness of breath and for this visit, pain.

For each issue documented under the Active Issues component, you can select the following descriptor:

1. **This Visit** (category 1) – issue is a focus of the current encounter (e.g. presenting complaints). It is not shared between encounters and not carried over to the next encounter.
2. **Chronic** (category 2) – issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. Chronic issues will appear under Medical History.
3. **This Visit and Chronic** (combination) – issue is marked as both categories. When marked as **Chronic** category, it is carried over to the next encounter

Note the difference when adding diagnosis versus problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (i.e. medical, social, or others).

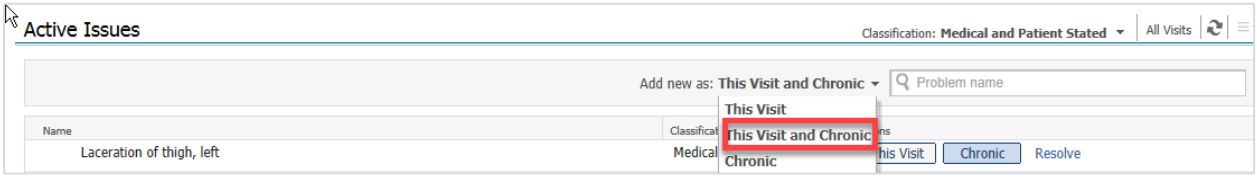
This Visit issues will be automatically resolved when patient is discharged. Chronic issues can remain active but also be resolved to become Historical issues.



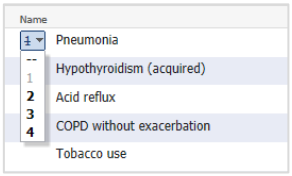
The diagnoses and problems recorded in Active Issues as chronic will carry over from visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.

1 To add Shortness of Breath to the patient's issues, select **This Visit** and **Chronic** and search for Shortness of Breath. This will carry over from this visit to the next.

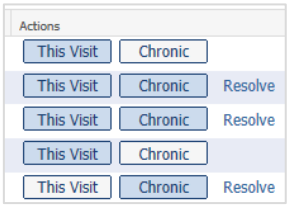
- Enter pain for **This Visit**.



2 You can also update problems right in this workflow view (for information only)



This visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.

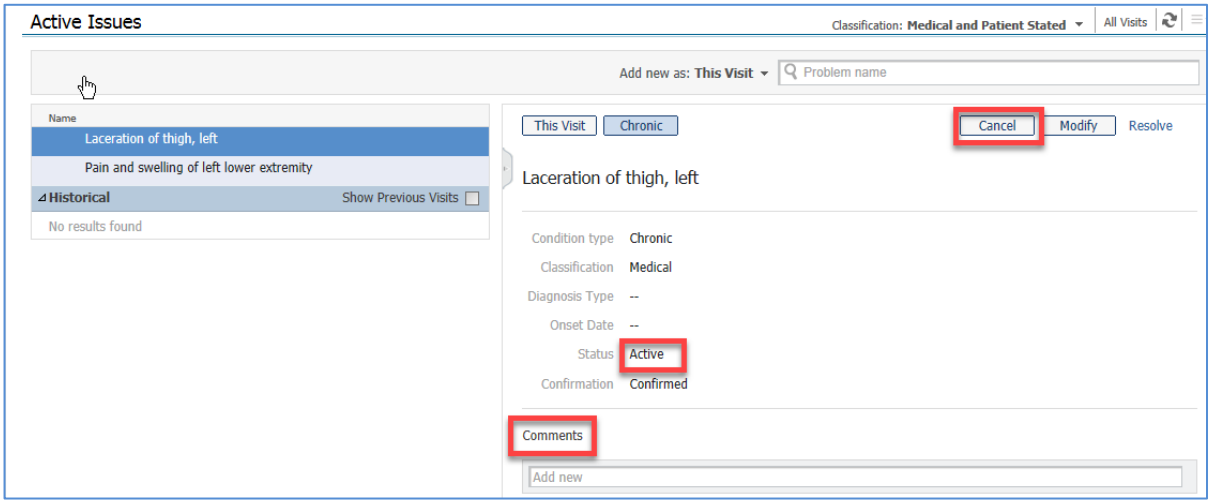


You can change any This Visit diagnosis to a chronic problem or both by clicking the appropriate buttons.

You can also click **Resolve** to move a problem to the Historical section.

3 Click the item to display more details. Without leaving this view, you can:

- **Cancel** this problem
- Type **Comments**
- Change the **Status**



4 For your practice, add *acid reflux* as **chronic** problem and **resolve** it. Remember to click the tab to collapse and remove the split screen.

5 To modify details, select the line and click **Modify** button.

For your practice:

- Add *sprain left ankle* as this visit problem and change it to a chronic problem.
- Add *ear infection* as chronic problem and resolve it.

Key Learning Points

- Use Active Issues to manage problems and diagnosis for patient's current visit.
- This Visit refers to diagnosis or problems for this current hospitalization.
- Chronic refers to past medical history that may be active during this hospitalization or may have already resolved prior to admission.

Activity 2.6 – Create a Progress Note and Use Auto Text Entry

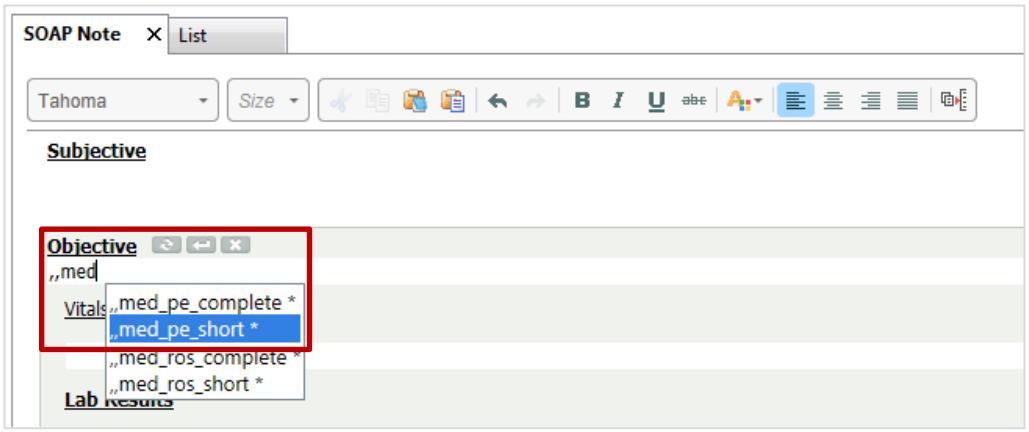
Similar to the Admission tab, the Rounding tab also provides one click access to the most relevant note type. You already know how to remove sections or edit text of your note. Now let's learn how to avoid entering repetitive information by using the auto text feature.

Now, you will create a **Dynamic Documentation** progress note for your patient.

1 From the list under **Create Note**, select **Progress Note** which will pull existing relevant information.

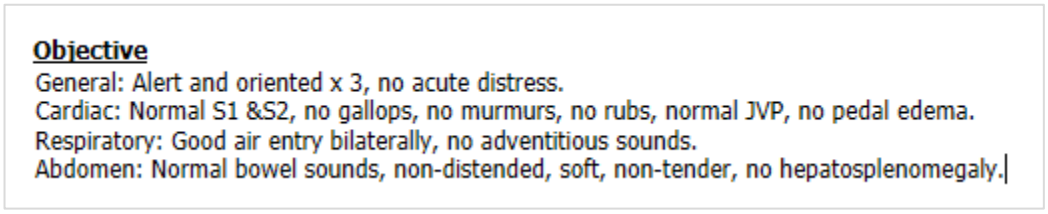
2 To use an **auto text** entry:

1. Activate a free text box under the **Objective** heading
2. Type **,,med**
3. A list of auto text entries starting is displayed. Double-click on **,,med**_pe_**short***



3 The programmed auto text entry populates in the box which can be modified by editing the text or left as is if appropriate.

Once completed click **Sign/Submit** to complete and close the progress note.



Note: Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own auto text entries. You will learn how to create auto text entries in a more personalized learning session.

Key Learning Points

- Use auto text entries for commonly entered information.
- Auto text entries shared between all providers help to maintain standards when documenting patient's care.

PATIENT SCENARIO 3 – Discharge a Patient to Home

Learning Objectives

At the end of this Scenario, you will be able to:

- Complete discharge steps, reconcile orders and medications.
- Update discharge diagnosis.
- Complete discharge documentation.

SCENARIO

Your patient has been improving and is ready to be discharged. You will complete the necessary steps and update the patient's chart. The following steps are required to discharge the patient when using the Clinical Information System (CIS):

1. Completion of discharge medication reconciliation including prescriptions.
2. Placing a Patient Discharge order for nursing and Registration.
3. Entering discharge diagnosis and any future investigation orders and referrals.
4. Creating a Discharge Summary.

You will complete the following 5 activities:

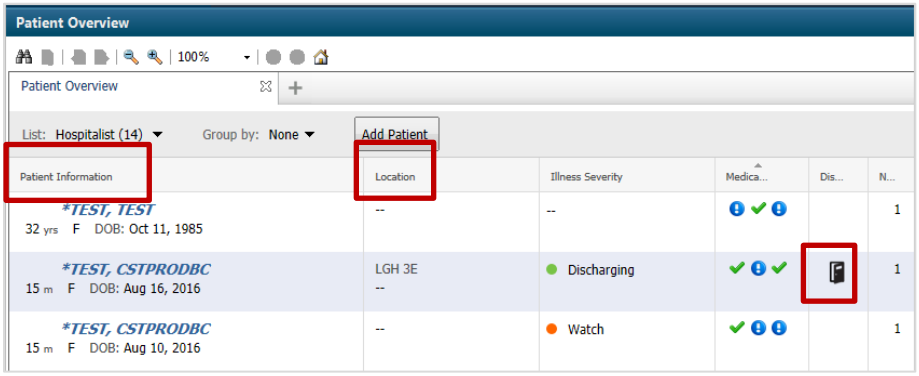
- Review orders.
- Reconcile medications at discharge and create prescriptions.
- Place orders when discharging a patient.
- Update discharge diagnoses.
- Complete discharge documentation.

Activity 3.1 – Review Orders

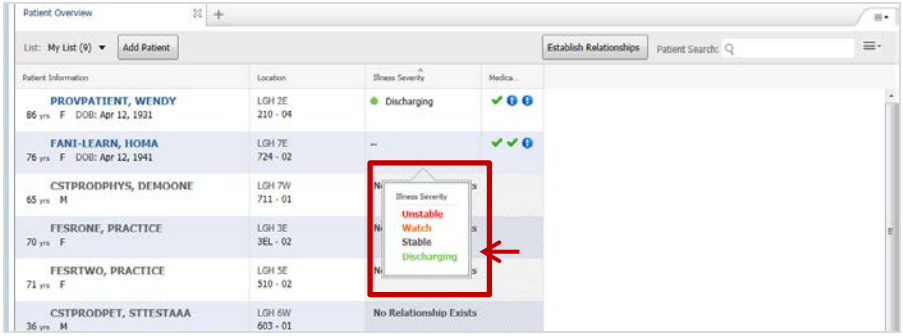
Continue to use the same patient. You can use **Patient Overview** to communicate with other providers about the patient's status. Although it does not create any action items, it serves as a **communication tool for patient handover**. It provides a snapshot of patient's status and also helps you manage your work:

1. You can track new results that you have not yet reviewed
2. You can see where the patient is located: unit / room / bed
3. You can make a note of a patient's illness severity
4. You can track medication reconciliation completion
5. Once the patient has a discharge order entered they will appear with the icon

Within a patient list, you can click column headings such as **Location** to display all patients in the same unit together. Clicking **Patient Information** will place names in alphabetical order.



Patient Overview also displays a snapshot of patient status under the **Illness Severity** column. You can easily add or change your patient status by clicking the corresponding space under this column and selecting one of the options from the list.

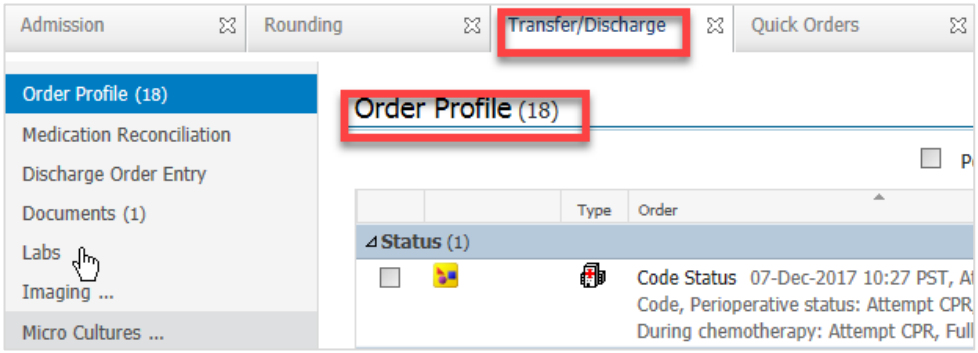


Note: You can click the column heading to group all patients ready for discharge.

1 To begin the process of discharging a patient, locate your patient's name in Patient Overview > My Assigned Patients list.

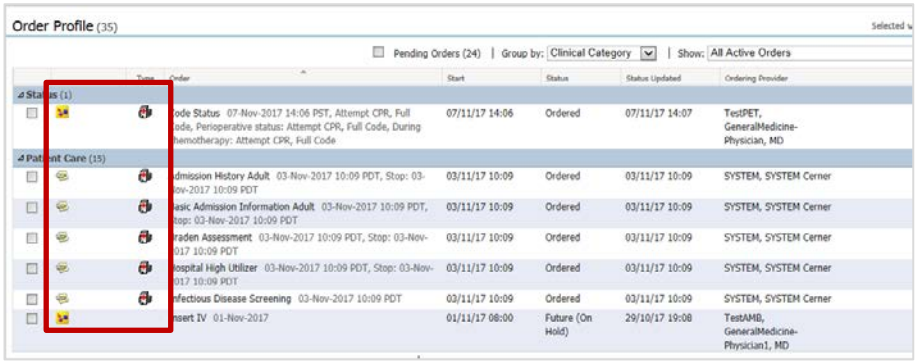
Mark him as **Discharging**, then open his chart.

2 In the **Discharge/Transfer** tab, select the **Order Profile** component.



3 Review patient's orders to be aware of any outstanding lab or imaging orders. Visual cues provide additional information. Describe the following icons:

indicates ?



Note: No manual action is required to stop orders at discharge. When a patient physically leaves the unit and is discharged from the system by the unit clerk or nurse, their encounter becomes closed. This will automatically discontinue their orders. Any orders to be completed in the future or orders with pending results that you have placed prior to discharge will remain active.

Key Learning Points

- Outstanding orders are automatically closed after discharge except future orders (completed after discharge) and orders with pending results.

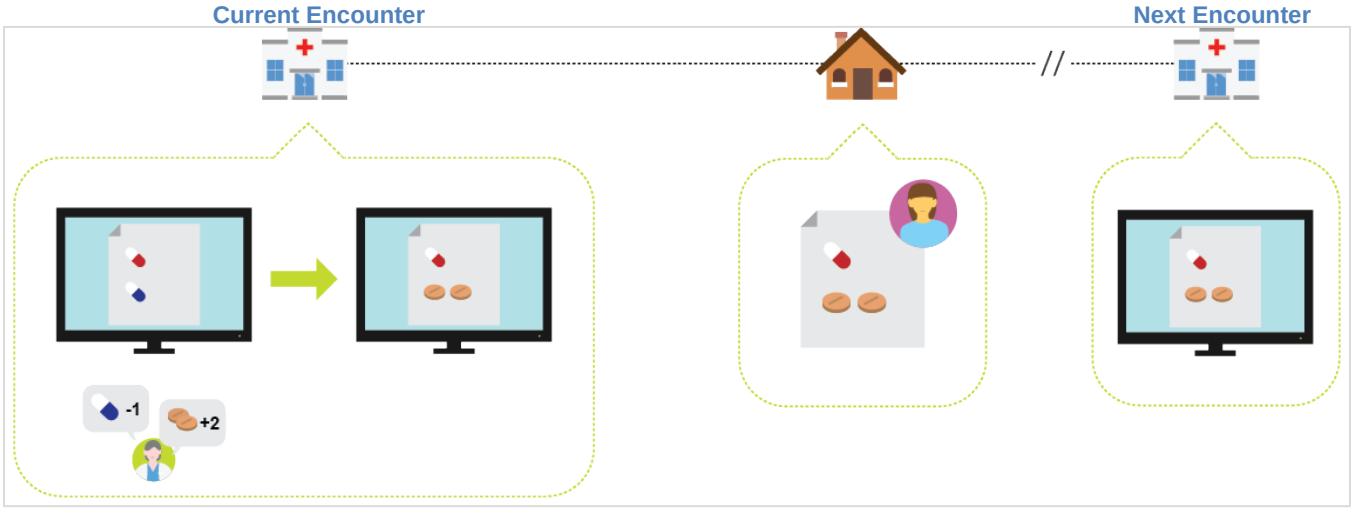
Activity 3.2 – Reconcile Medication at Discharge and Create Prescriptions

Now that you have reviewed the current orders, you are ready to complete your discharge medication reconciliation. The list of medications to reconcile includes:

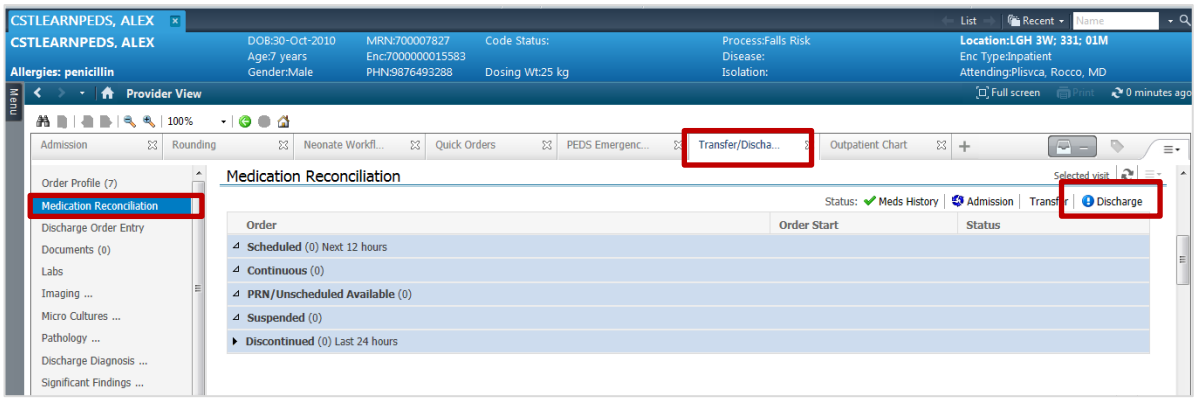
1. **Home Medications** – medications that the patient was taking at home prior to admission. These medications were documented with BPMH but were **not** continued during the hospital visit.
2. **Continued Home Medications** – medications the patient was taking at home prior to admission and continued during this admission.
3. **Medications** – new medications that the patient started during this inpatient stay.
4. **Continuous Infusions** – inpatient fluids and medications that were given by continuous infusion.

You will determine which medications your patient should continue after discharge. Continued medications will be carried forward and available as documented home medications within the patient's medication history. You can also create a prescription for the existing or new medications directly in the reconciliation screen.

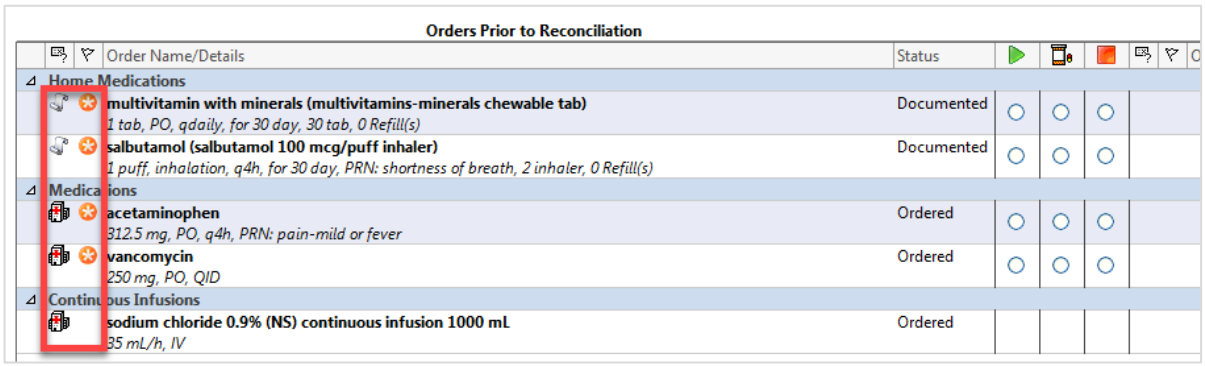
All medications marked to be continued at home during discharge will be viewable at the patient's next visit.



1 Navigate to the **Medication Reconciliation** component of the **Transfer/Discharge** tab, and click **Discharge**.

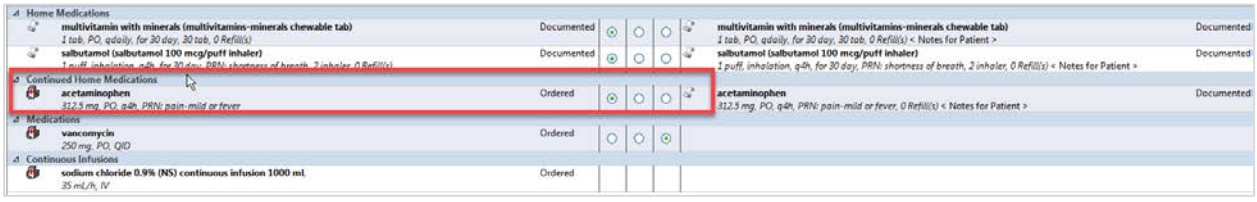


2 The reconciliation window displays the current status of medications.



3 **Home Medications** that the patient should re-start taking at home, click **Continue** and home medications that the patient should discontinue permanently, click **Do Not Continue After Discharge**.

4 For the **Continued Home Medications**, select appropriate radio button to continue or stop.

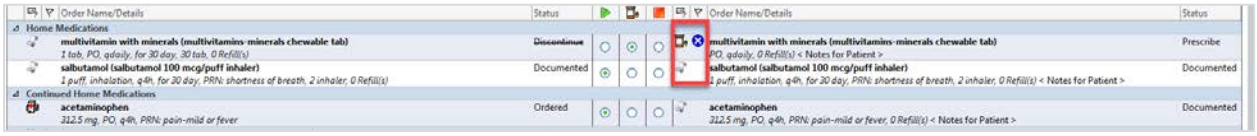


Note: If home medications are to be continued, select documented medication marked by  rather that inpatient orders marked by  icon.

When the patient discharge summary is printed, it clearly identifies which home medications are continued and which must be stopped.

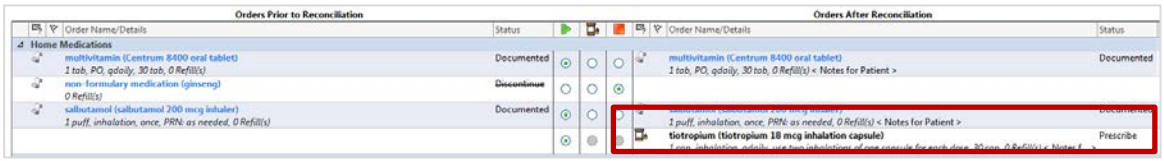
5 Make your selection for the remaining medications.

To create a prescription for Salbutamol and Acetaminophen: click column marked with and add missing details as indicated by the icon.



Note: discharge summary documentation will clearly list which new prescriptions to start taking.

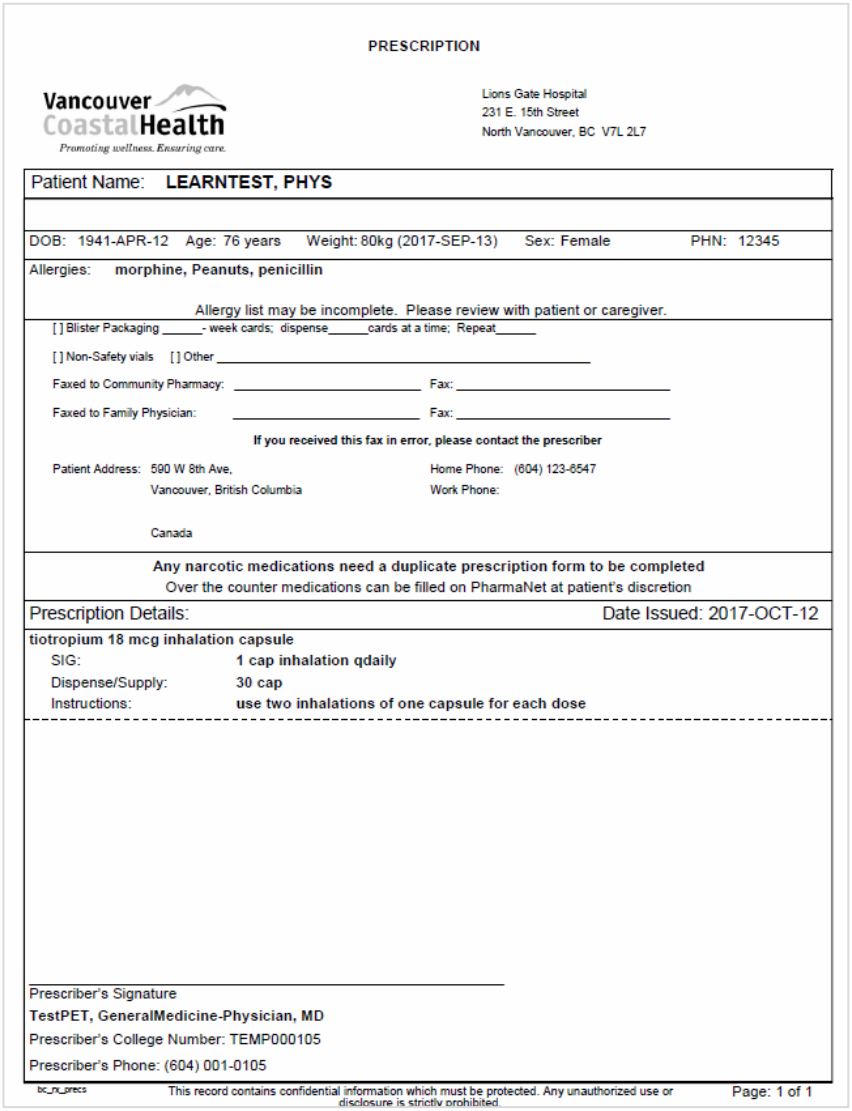
6 You can also add additional prescriptions for medications that will be new for the patient. Click the Add icon to add Multivitamin once daily.



7 All medications must be reconciled to successfully complete the discharge medication reconciliation process.
Once all medications are reconciled, click **Sign** to complete discharge medication reconciliation.

The following will happen:

- The **Document Medication by Hx** list (BPMH) will be populated by medications that you selected to continue. Prescriptions will be added to this list.
  Home medications that are not continued in current discharge reconciliation will be dropped and removed from the list.
- The prescription will print automatically.



PRESCRIPTION

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Lions Gate Hospital
231 E. 15th Street
North Vancouver, BC V7L 2L7

Patient Name: **LEARNTEST, PHYS**

DOB: 1941-APR-12 Age: 76 years Weight: 80kg (2017-SEP-13) Sex: Female PHN: 12345

Allergies: **morphine, Peanuts, penicillin**

Allergy list may be incomplete. Please review with patient or caregiver.

[ ] Blister Packaging _____- week cards; dispense_____cards at a time; Repeat_____

[ ] Non-Safety vials [ ] Other _____

Faxed to Community Pharmacy: _____ Fax: _____

Faxed to Family Physician: _____ Fax: _____

If you received this fax in error, please contact the prescriber

Patient Address: 590 W 8th Ave, Vancouver, British Columbia Canada

Home Phone: (604) 123-6547
Work Phone:

Any narcotic medications need a duplicate prescription form to be completed
Over the counter medications can be filled on PharmaNet at patient's discretion

Prescription Details: Date Issued: 2017-OCT-12

tiotropium 18 mcg inhalation capsule

SIG: **1 cap inhalation qdaily**
Dispense/Supply: **30 cap**
Instructions: **use two inhalations of one capsule for each dose**

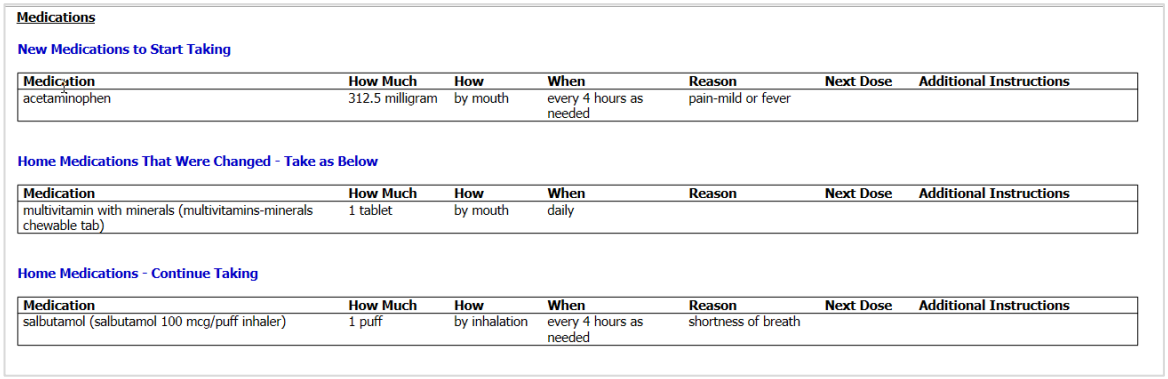
Prescriber's Signature
TestPET, GeneralMedicine-Physician, MD
Prescriber's College Number: TEMP000105
Prescriber's Phone: (604) 001-0105

bc_rt_precs

This record contains confidential information which must be protected. Any unauthorized use or disclosure is strictly prohibited.

Page: 1 of 1

A medication summary will be included in the Patient Discharge Summary as well as in the Discharge Summary.



Medications

New Medications to Start Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
acetaminophen	312.5 milligram	by mouth	every 4 hours as needed	pain-mild or fever		

Home Medications That Were Changed - Take as Below

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
multivitamin with minerals (multivitamins-minerals chewable tab)	1 tablet	by mouth	daily			

Home Medications - Continue Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
salbutamol (salbutamol 100 mcg/puff inhaler)	1 puff	by inhalation	every 4 hours as needed	shortness of breath		

Key Learning Points

- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process.
- Continued medications and prescriptions will be captured in the patient's Document Medication by Hx list (BPMH) and carried forward to the next visit.
- Discontinued home medications will not be included in the Document Medication by Hx list (BPMH).
- Discharge medication information is included in the discharge summary that is forwarded to patient's lifetime providers and to the patient.

Activity 3.3 – Place Orders when Discharging a Patient

The **Discharge Patient** order creates tasks informing the team that the patient is ready to be discharged. The order is also required by Hospital Act Regulation. After the patient physically leaves the hospital, the encounter can be closed.

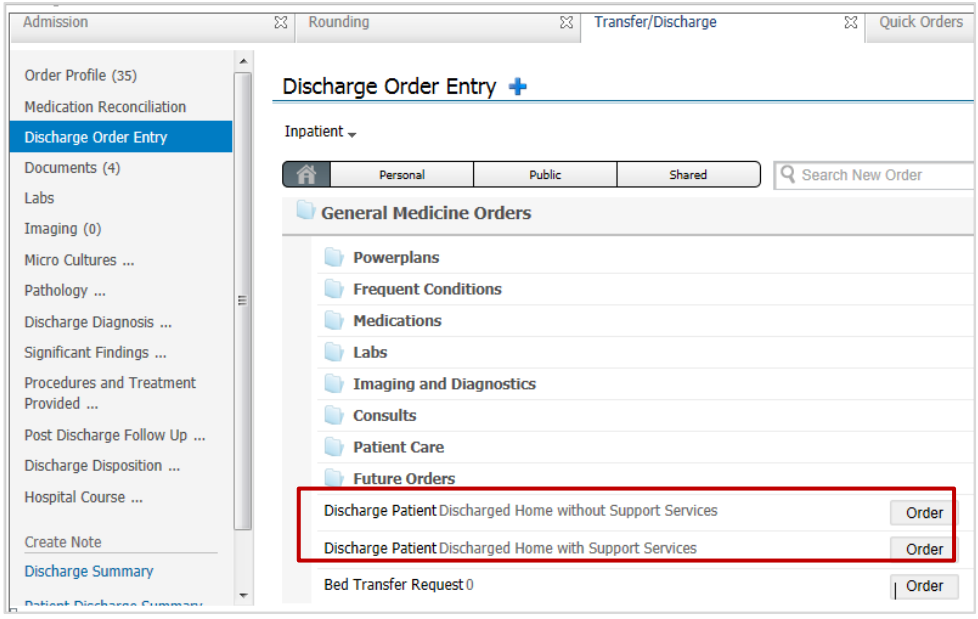
However in the Clinical Information System (CIS), you have the ability to create orders to be completed after the patient has been discharged. This applies to orders to be done post-discharge:

- Referrals
- Investigations such as labs/imaging are also called **future orders**

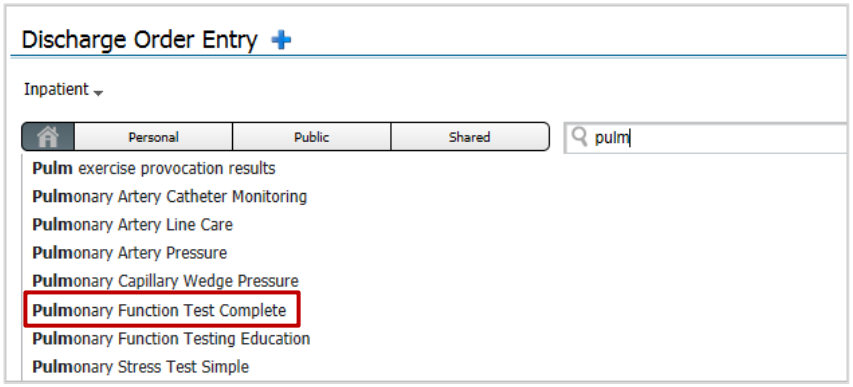
If a specimen is expected to be collected either at home or at an external facility, a printed requisition will be given to the patient.

For this patient, you decide to place a future order for a Pulmonary Function Test. You also want to provide him with a referral to a Respirology – Asthma.

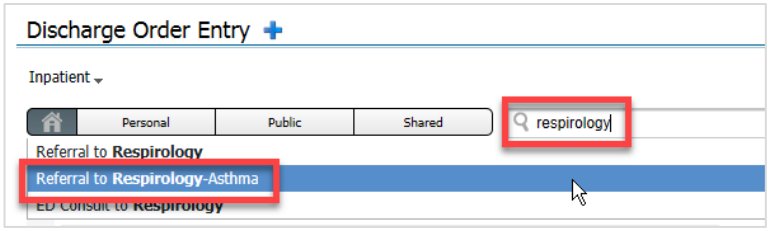
1 In the **Transfer/Discharge** tab, select **Discharge Order Entry** and select the appropriate order sentence. For our example, click **Order** to select **Discharge Patient without Support Services**.



2 To add a **Pulmonary Function Test** as a future order, search the catalogue directly from the current component. Search and select the order from the drop-down.

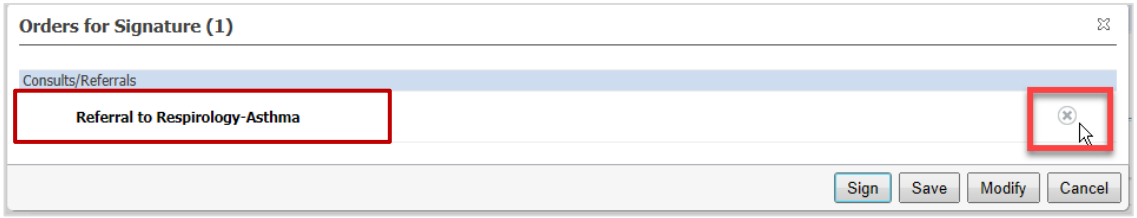


3 Repeat steps to add the referral to Respirology – Asthma



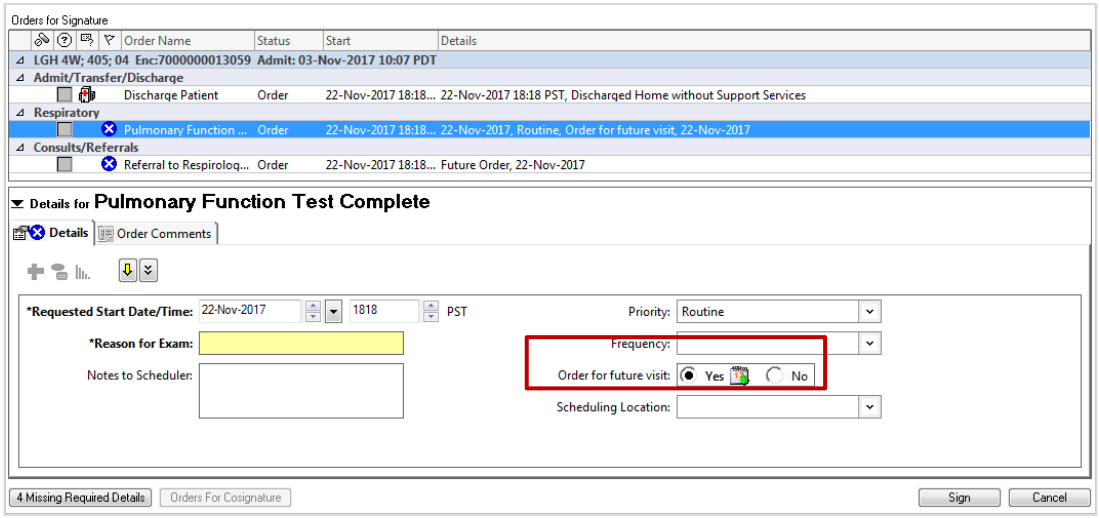
4 Once you placed all orders, click the **Orders for Signature** icon, and then click **Modify**.

Note: Place the cursor over the individual order in the Orders for Signature window, and click x on the right side to remove an order placed in error.



5 Click the order name to display **Details** and add missing required details.

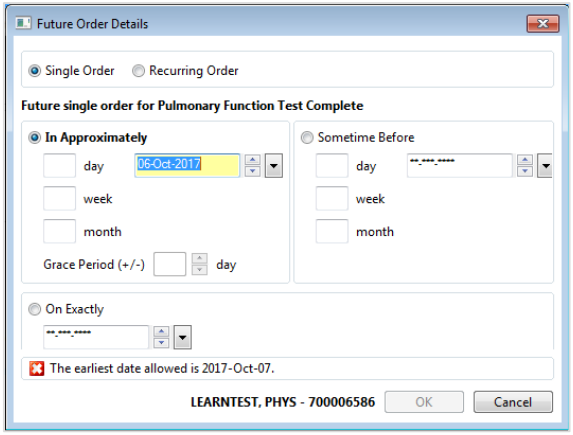
Check **Yes** for **Order for future visit** and click the calendar icon 

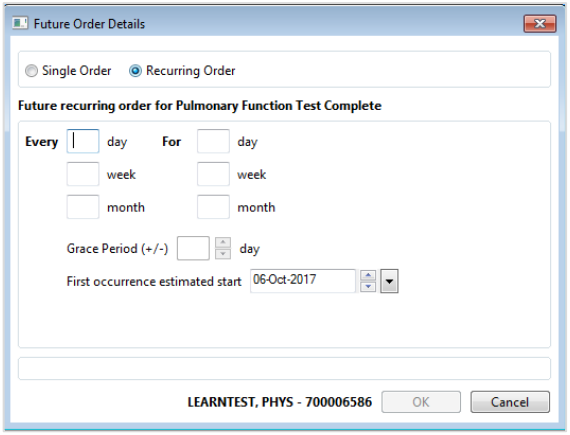


6 You have an option to select different details recommending when the test should be completed or if it has to be repeated. Select one of the options:

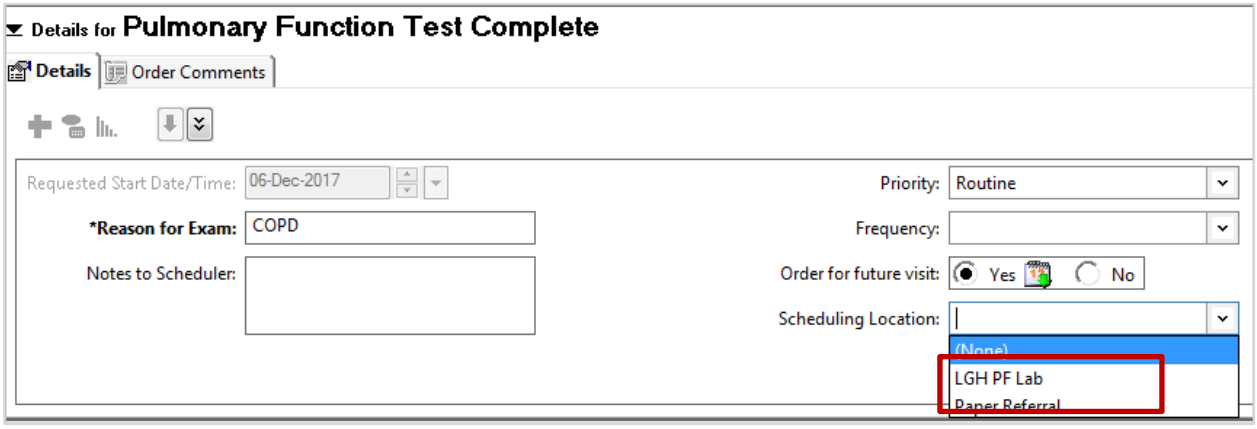
- One time test (single order) or recurring
- An approximate time from now
- An approximate time before a specific date
- Time range in days for a grace period
- Exact date

Note: These details are to guide appropriate booking not to book the actual test.



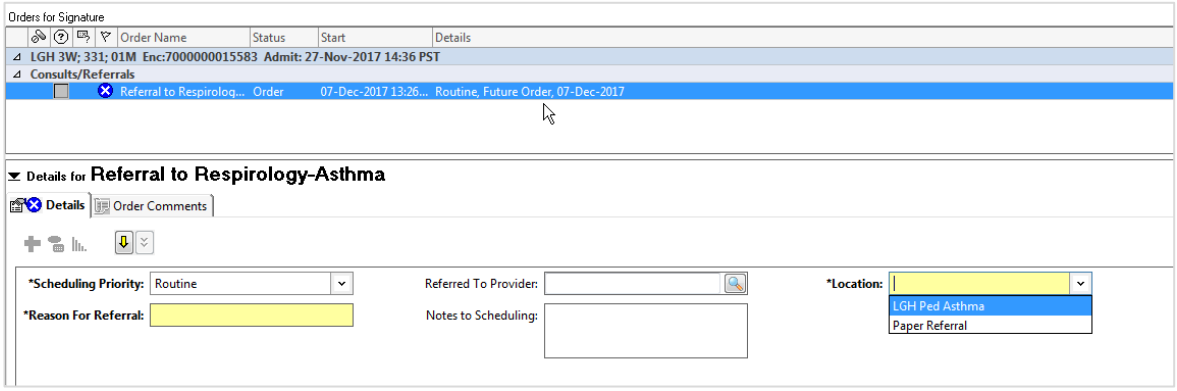


7 From the **Location** drop-down, you can select any location that is part of the system. For our example, select LGH PF Lab. In real life, the lab selected will be prompted to proceed with the order.



Note: For locations that are not part of the CIS, the **Paper Referral** option is to be selected. Although the process remains on paper, placing this order in the CIS informs care providers for this patient that the specific referral has been placed.

8 For your practice, add missing mandatory details for the referral.



Key Learning Points

- A Discharge Patient Order documents the decision to discharge a patient (required by the Hospital Act Regulation) and informs patient Registration and the nurse.
- Future orders (investigations) and referrals can be ordered after discharge and remain active.
- You can easily place recurring future orders using appropriate options.
- Selecting a specific location prompts individuals at the location that the order has been placed.
- Selecting Paper Referral indicates that the process remains manual as the facility/provider may be practicing outside of the CIS; the order is captured in the patient's electronic chart.

Activity 3.4 – Complete Discharge Diagnosis and Discharge Documentation

Continue to work through the discharge workflow on the Discharge Patient tab. Review the following:

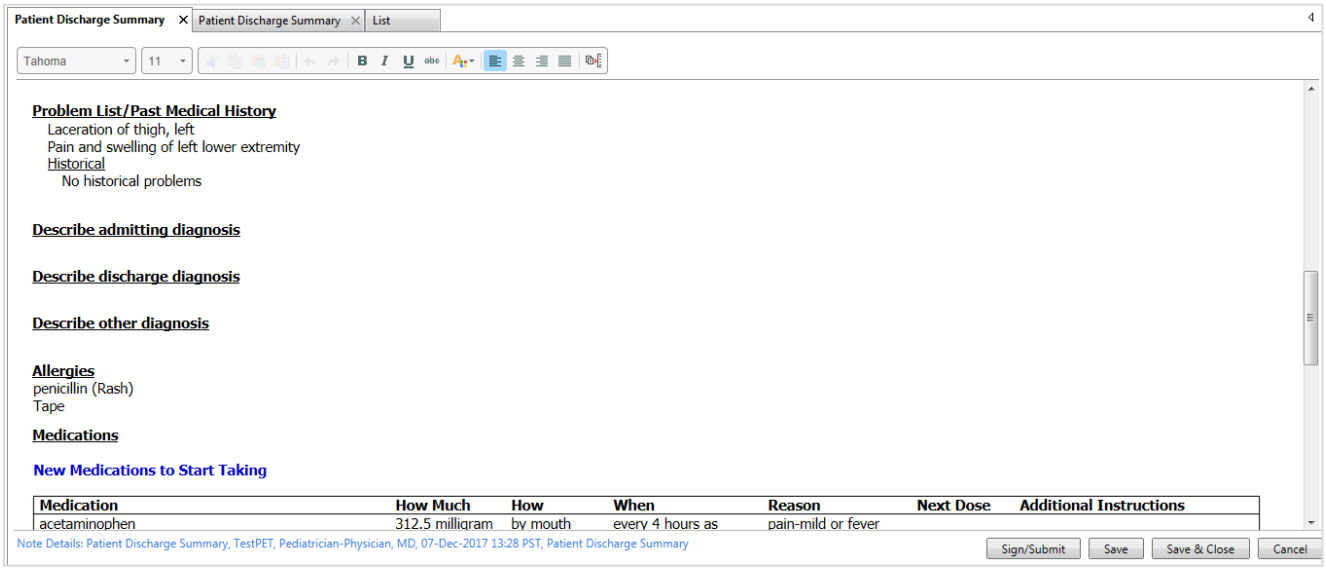
1. Documents
2. Labs
3. Microbiology
4. Pathology
5. Imaging - Click XR Chest under Imaging to review the result

Using **Dynamic Documentation**, you will create the discharge notes.

This note type will use a unique feature of the of the **Hospital Course** component. Unlike other free text components such as Illness History where you enter your own temporary notes, the Hospital Course component is visible to other providers to enable collaborative input. This free text box accumulates entries from multiple provides. This collaborative comment is pulled into a Discharge Summary note with one click.

The CIS provides links to two discharge document types:

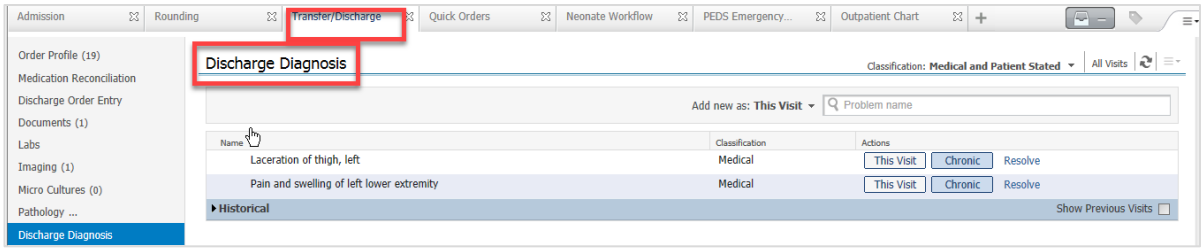
- **Discharge Summary** – to be distributed through Excelleris to the list of automatically included providers. You can also select other providers who should receive a copy.
- **Patient Discharge Summary –** to be printed by a nurse and handed to the patient.



The Dynamic Documentation allows for finishing your documents later. If you are interrupted you have a choice:

- **Save** – will save the information and documents remains open so you can continue working.
- **Save & Close** – will save the information and close the document. It will be saved as draft under Documents component and sent to your Message Centre. Draft document is only visible to you.

1 Ensure you are in the **Discharge/Transfer** tab of your patient's chart and select **Discharge Diagnosis**.

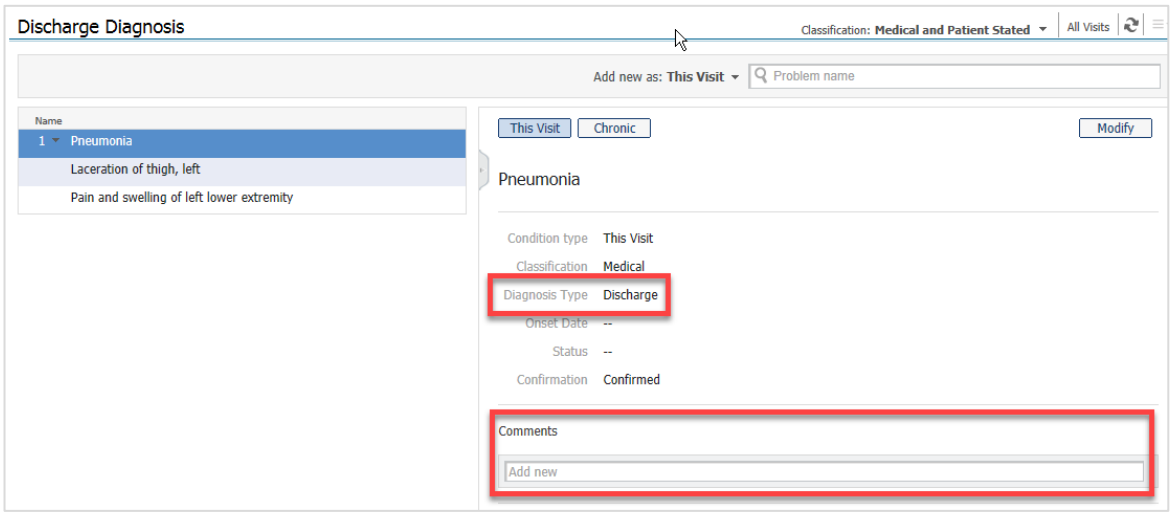


2 Confirm problems and diagnoses status at discharge:

Expand details for pneumonia to ensure it states that this is a discharge diagnosis and note the status.

Ensure that PAIN applies to **This Visit** and Diagnosis Type is **Discharge**.

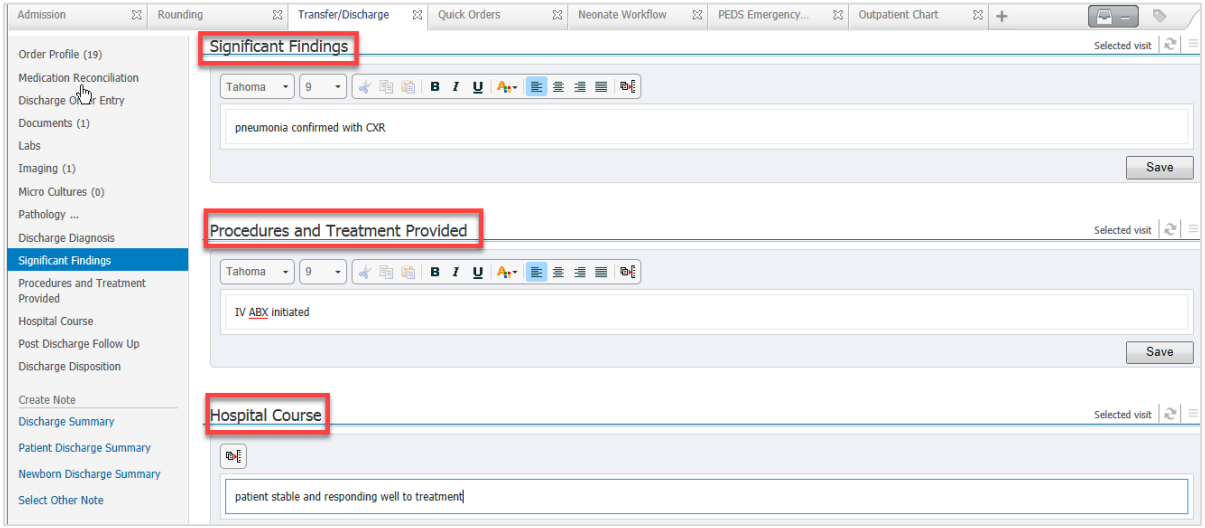
Note: You can add comments for better communication with other care team members.



3 Start documenting patient's discharge by typing information under:

- Significant Findings
- Procedures and Treatment Provided
- Hospital Course

Entries made in these fields will auto-populate into your discharge summary. Remember that you can use auto text entry to speed up the process.



4 In the **Hospital Course** component, many providers can document on the patient. All these entries are stored until the Discharge Summary note is created.

5 Once you are ready to create discharge notes, click the note links provided under **Create Note**. There are two note links available there:

1. **Patient Discharge Summary** (to be provided to the patient)
   - Add information and click **Sign/Submit** to complete now.
2. **Discharge Summary** (to be distributed to other providers)
   - Click **Save & Close** to complete later. Your document will be listed under Documents as well as sent to the Message Centre.

Key Learning Points

- You can fully manage discharge diagnosis right in the Transfer/Discharge tab.
- A Patient Discharge Summary is generated for the patient to take home at the time of discharge. Nursing staff will print and provide this to the patient after you sign it.
- A Discharge Summary will be distributed to the providers who have documented lifetime relationships on the patient's record and to any other providers selected by you
- Sign/Submit completes the document.
- Saved documents can be completed later.

PATIENT SCENARIO 4 – Transferring a Patient

Learning Objectives

At the end of this Scenario, you will be able to:

- Complete patient transfer related tasks in the Clinical Information System.

SCENARIO

When you transfer your patient to an external site, the Clinical Information System (CIS) requires you to discharge the patient from the current site. The current encounter is closed. The receiving provider accepts the patient and completes steps for admission at the receiving site.

If the receiving site uses the CIS, the receiving provider has electronic access to patient information. If patient is moving to or coming from a site that has not implemented the CIS, providers will use paper-based documentation.

Transfer scenarios are difficult to recreate in training situation. Both internal and external transfers involve many health care professionals. Keeping this limitation in mind, you will complete the following 3 activities:

- Initiate a transfer from Inpatient to PICU and place a Bed Transfer Request order.
- Reconcile medication and non-medication orders at transfer of care.
- Place a ‘Discharge to External Site’ order.

Activity 4.1 – Initiate Transfer From Inpatient To PICU and Place Transfer Orders

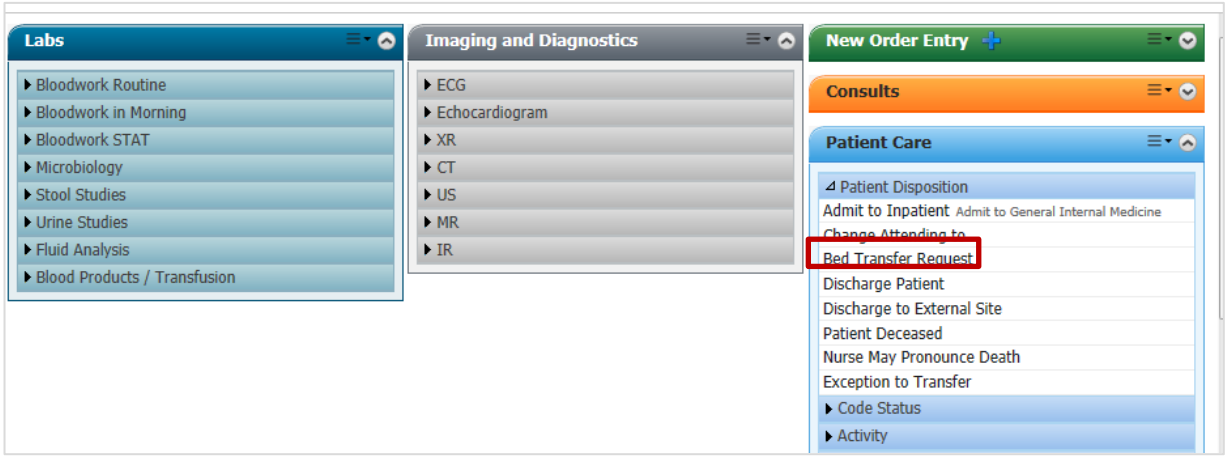
Note: In the interest of training purposes, in this activity we assume that the child is progressively worsening and being transferred to an onsite PICU. These steps would be followed for any unit transfers within the same hospital. Activity 4.3 specifically discusses transfer to external sites.

Once the decision to transfer a patient is made by the provider, physician to physician communication takes place outside of the Clinical Information System (CIS) to ensure proper transfer of responsibilities. It is important that the sending physician still discusses all aspects of care and shares any concerns with the receiving physician.

You consult the PICU provider and discuss your patient who is deemed an appropriate transfer to the PICU. The charge nurse is made aware and prepares for the patient‘s transfer.

To initiate the patient transfer and locate an appropriate bed for the patient, a **Bed Transfer Request** order is placed. This order is typically placed by the Charge Nurse of the sending unit; however, a provider may also enter this order.

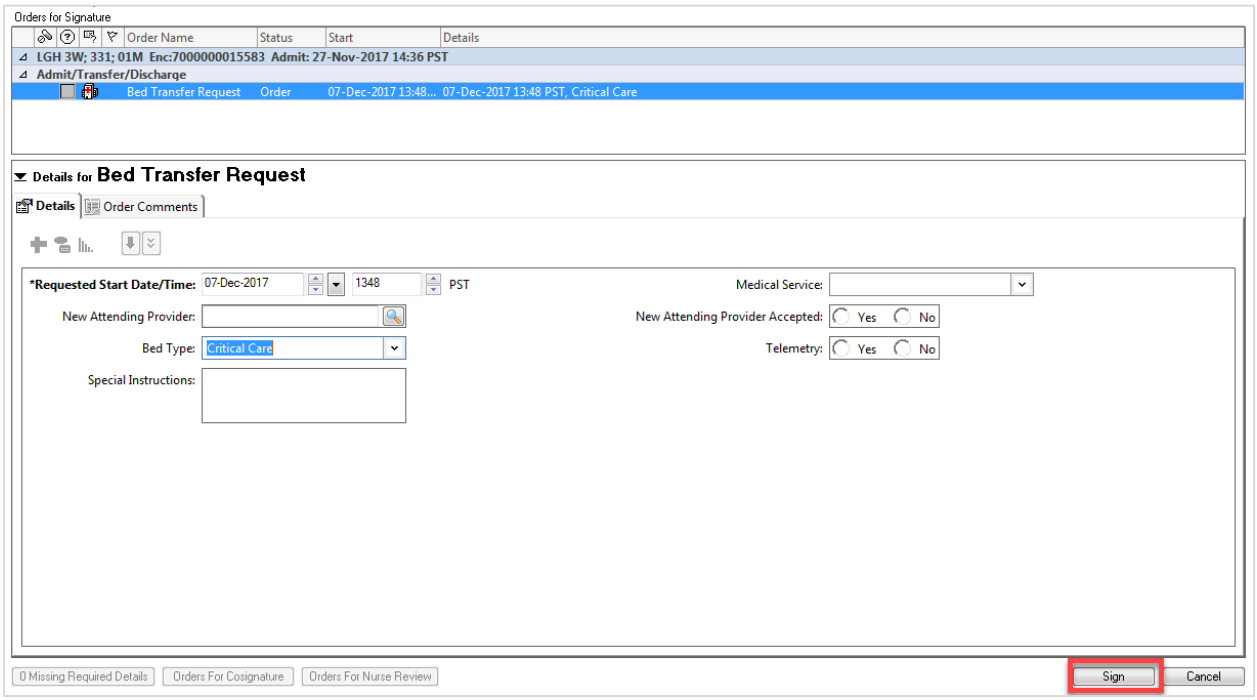
1 Place the Bed Transfer Order from the **Quick Orders tab > Patient Disposition** folder.



2 In the **Orders for Signature** window, click **Modify** to add details that you think are necessary:

- Name of the new attending provider
- Bed type
- Medical Service
- If patient has been accepted by the new provider

3 Click **Sign** to complete the process.



Key Learning Points

- The Bed Transfer Request order initiates the process of searching for a bed. It also allows for identifying new medical service and transferring responsibility of care.
- Verbal communication between units and physicians is critical.

Activity 4.2 – Reconcile Medication and Non-Medication Orders at Transfer of Care Within The Site

When transferring a patient to a different level of care, all current medications and orders must be reconciled.

The transfer medication reconciliation is similar to the admission reconciliation; however, it also includes **non-medication orders**. In the Clinical Information System (CIS), this task may be performed as many times as necessary, whenever a patient is transferred. The transfer reconciliation window is a convenient tool to review all of the patient's medications and orders in one step.

The receiving provider is generally the one responsible for completing transfer medication reconciliation with the exception of the critical care. The Critical Care provider will be the one responsible for completing the reconciliation when accepting and when sending the patient. When the Critical Care provider transfers the patient out of the Critical Care unit, he or she will plan transfer medication reconciliation and the receiving provider will review and sign it to initiate orders once the patient has arrived to their new unit/patient care area.

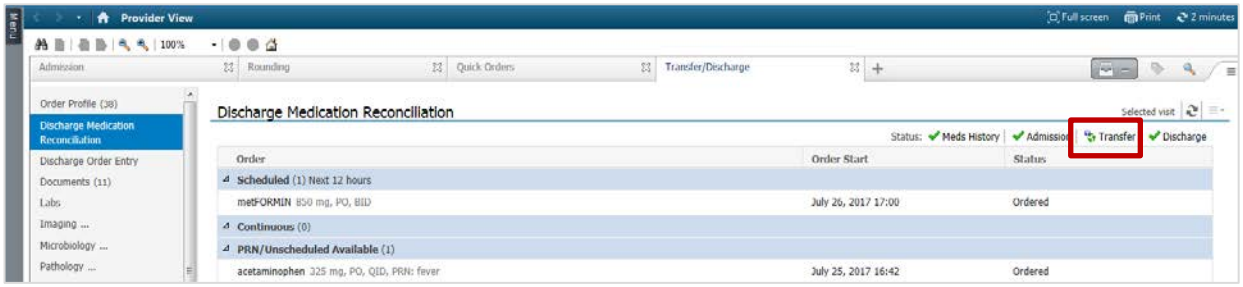
When this patient is being transferred back to the Pediatric unit, the Critical Care provider plans transfer reconciliation and you as the hospitalist will review the orders, make adjustments if necessary, and sign.

The transfer reconciliation displays medication and non-medication orders. On transfer within the hospital, you can continue orders that are already in place. This allows for safe and effective transfer of care. The Transfer Orders Reconciliation provides two options:

1. Clicking **Sign** will initiate appropriate decisions from the Transfer Reconciliation.
2. Clicking **Plan** will continue current orders and simply save decisions.

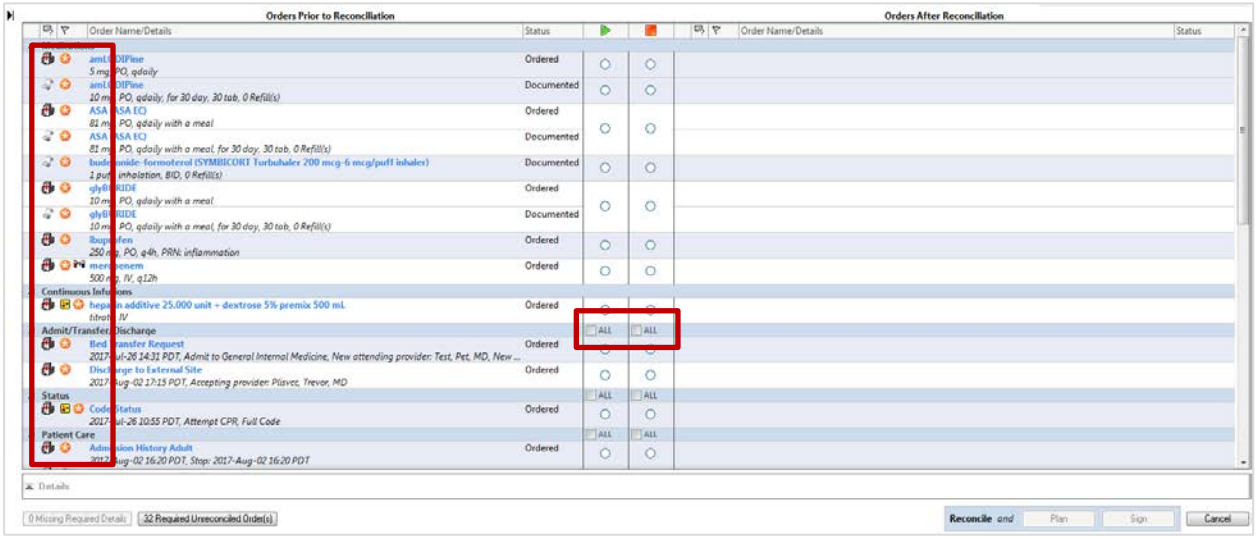
Verbal communication outside of the CIS is necessary to ensure that intentions of both the sending and receiving provider are clear:

1 In the **Transfer**/**Discharge** tab, display **Medication Reconciliation** component. Click **Transfer**.



2 The Transfer Reconciliation screen displays. You are now familiar with these icons.

Note: you can click **All** to select all non-medication orders you would like to stop or continue, with one click.



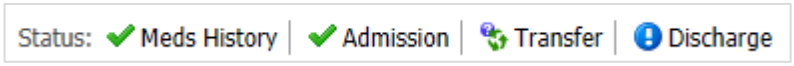
3 For your practice, make the appropriate selections. You can choose one of the two options:

- **Sign** – to complete the process, and activate orders immediately Plan,
- **Plan** – to save your selections to be activated at a later time.

When a patient is transferred out of the PICU, the intensive care provider makes decisions about current orders and chooses **Plan** so the orders continue until the receiving provider signs off.

When transfer reconciliation is in a **planned** status, provider's decisions remain saved but orders and order changes will not be active. Patient care is continued per current state orders until the transfer reconciliation is signed.

The status of planned transfer reconciliation is partial pending indicated by icon.



In this situation, the receiving provider clicks the Transfer button to display pending Transfer Reconciliation window. The receiving provider reviews orders and makes decisions to continue, discontinue, or add orders. Sometimes it might be appropriate to stop all current orders and place new ones.

Key Learning Points

- The receiving provider is responsible for the review and signature of the transfer medication and non-medication reconciliation upon receipt of the patient.
- When the Intensive Care provider transferring patient out of the Intensive Care unit, leaves the reconciliation in planned status (selects Plan); Current orders continue until the receiving provider signs off.

Activity 4.3 – Complete Patient Transfer to an External Site

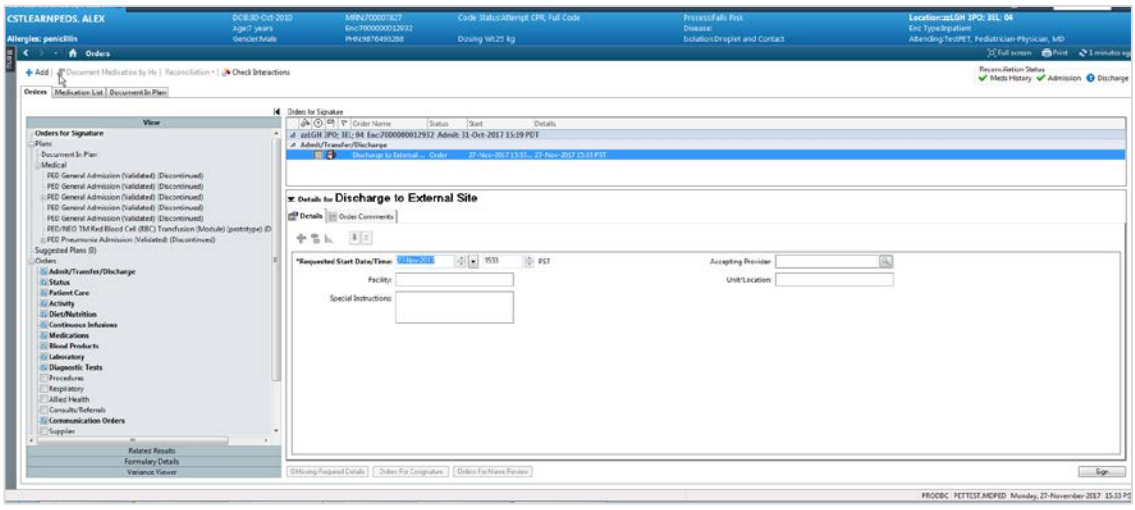
If your current location cannot provide the necessary level of care, the patient requires transfer to another site.

You contact Patient Transfer Network (PTN) to identify the receiving provider and arrange for provider to provider communication. This action takes place outside of the Clinical Information System (CIS). In this example, a receiving provider has been identified and has accepted the patient. You completed handover and the patient is now ready to be transferred.

To proceed with transfer, you will discharge the patient from your site. It is not possible to complete this scenario in the classroom but you know the discharge process from previous activities.

When the receiving provider accepts the patient, you initiate the process of discharging your patient by placing a **Discharge to External Site** order. For transfers to external sites, the **Discharge Medication Reconciliation** process must be done as in activity 6.2.

1 For your practice, use one of the techniques you have learned before and place a **Discharge to External Site** order.



Where would you find this order?

Which reconciliation type will you complete?

What notes will be created?

Key Learning Points

- When transferring your patient to an external site, you discharge the patient from the current site. This includes discharge medication reconciliation and a discharge summary.
- Discharge to External Site order initiates the process of moving your patient to another site.
- If the external site uses the CIS, the patient chart is available for the receiving team but paper-based documentation may still be required as per organizational procedures.

NEWBORN – Neonatal Functionality

Learning Objectives

At the end of this Scenario, you will be able to:

- Review the Neonate Workflow Tab
- Create admission notes with auto-text
- Locate newborn reports
- Locate the bilirubin nomogram and newborn record

SCENARIO

The following activities step outside the initial patient scenario in order to demonstrate newborn-specific tasks and documentation.

NOTE: This newborn section of the workbook is intended primarily for those pediatricians who routinely attend births, provide care for newborns, or work with NICU patients. However, **any pediatrician may provide care for infants, so it is strongly suggested that all pediatricians read through the material.**

Because this material is outside the workbook's scenario of a 7-year-old male, **ask your instructor if newborn patients are available for today's session**. If they are not, this section may be read-only as this functionality only becomes available within a newborn's chart or a mother's chart in the Labour and Delivery unit.

You will complete the following activities:

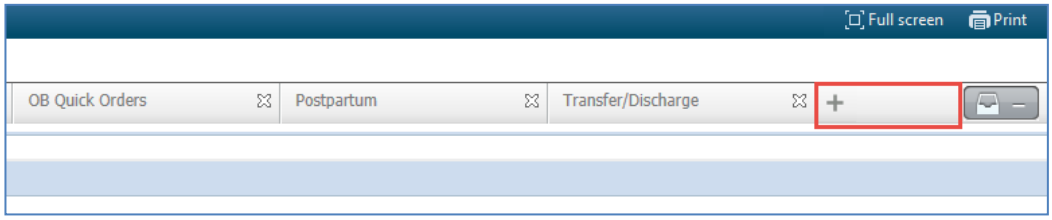
- Locate and Review the Neonate Workflow tab
- Document Newborn Delivery Data in iView
- Review and document the Newborn BPMH
- Locate the Newborn Record report
- Add Active Issues for the Newborn
- Locate the Bilirubin Nomogram
- Review the Task Timeline

Activity 5.1 – Locate and Review the Neonate Workflow Tab

1

Adding or removing workflow tabs

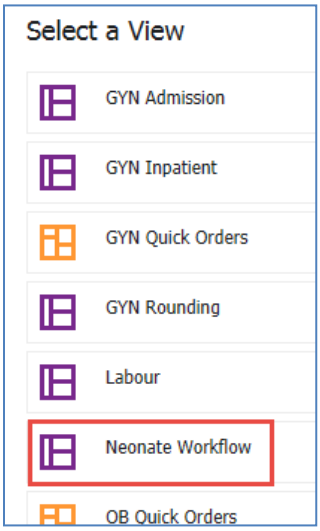
If you cannot locate the Neonate Workflow tab in the mother's chart, click the add button + in the workflow tabs bar.



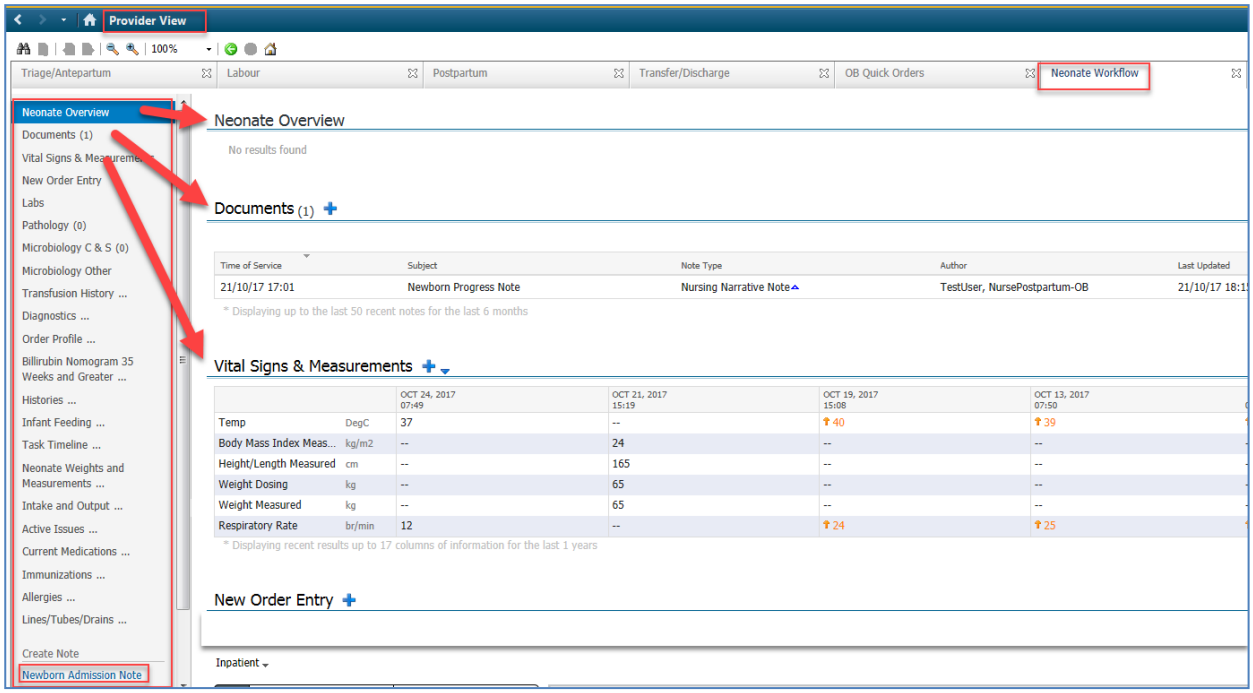
2

From the **Select a View** list, click **Neonate Workflow**. It is now added to your workflow tabs.

You may also remove a tab from the row by clicking the remove icon.



3 Now that you are in the **Neonate Workflow** tab. Let's go ahead and review the components. Vital Signs are pulled in from the nursing documentation in iView. Notice that the Newborn Admission Note is found at the end of the component list.



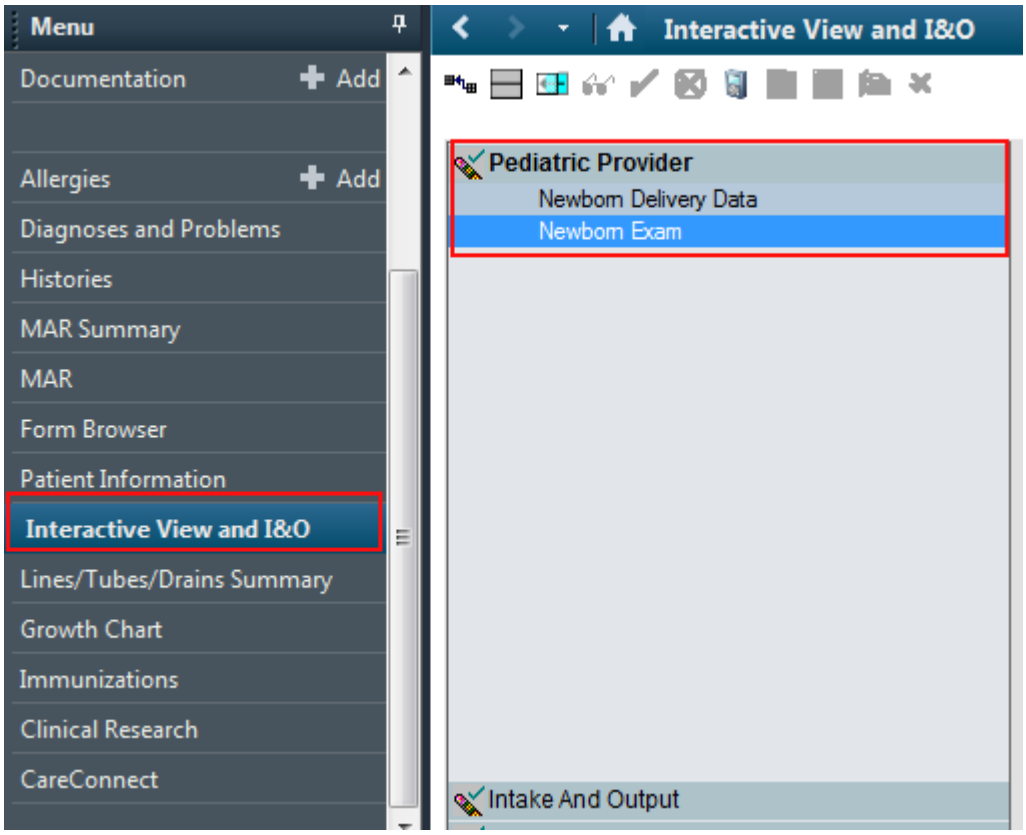
Key Learning Points

- The Neonate Workflow tab displays newborn specific iView information such neonate overview, vital signs and measurements, documents, labs, etc.
- You can also add a workflow tab by clicking on the add button at the end of the tabs.

Activity 5.2 – Document the Newborn Delivery Data in iView

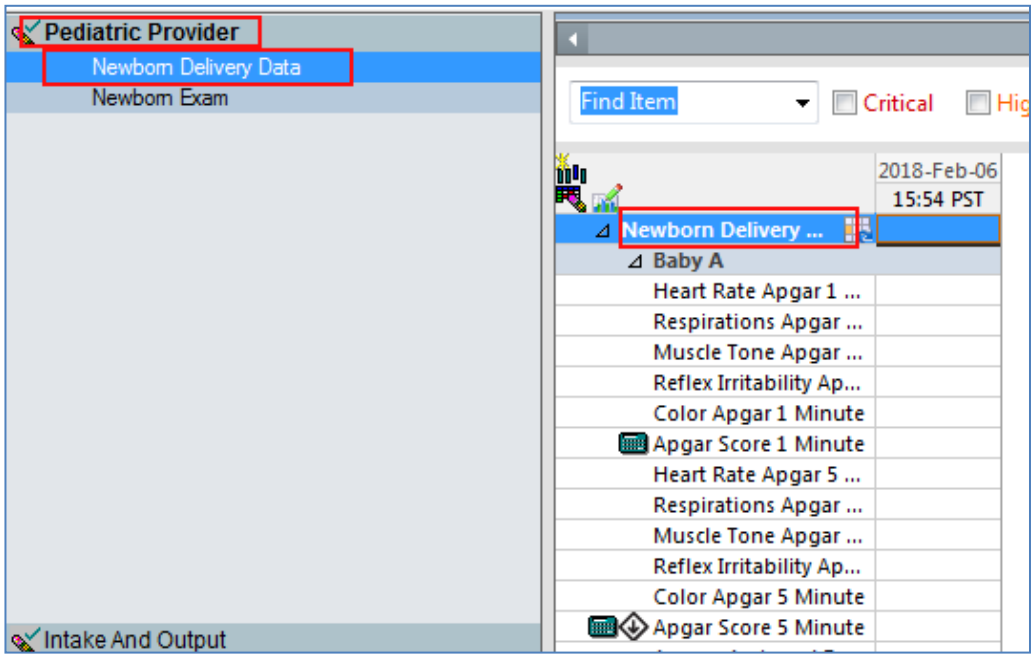
1 Document the Newborn Delivery Data in the **mother's chart.**

From the Menu, click **Interactive View and I&O**



2

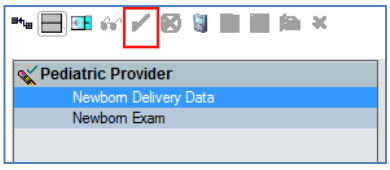
- Click on **Pediatric Provider** band
- Click on **Newborn Delivery Data** section
- Double click on blue **Newborn Delivery Data** line to open the cells for one click documentation. Use the tab key to advance your documentation.



3 Enter the following data into the Newborn Delivery flowsheet:

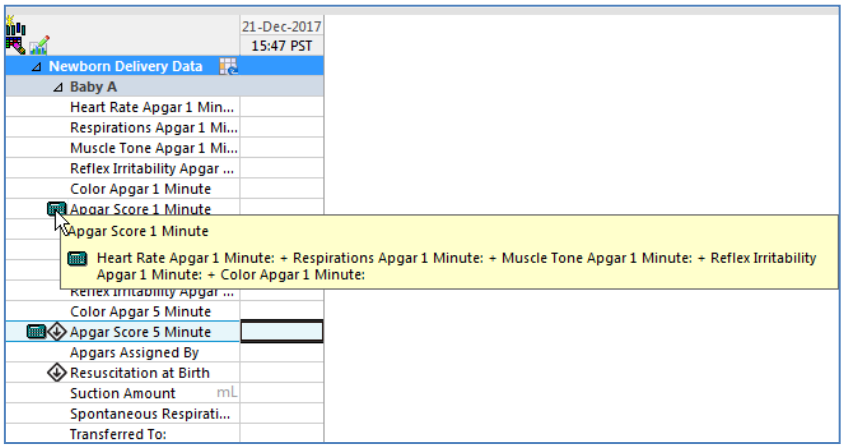
- **Heart rate Apgar 1 minute** = greater *than 100 beats per minute*
- **Respirations Apgar 1 minute** = *good, strong cry*
- **Muscle Tone Apgar 1 minute** = *active motion*
- **Reflex irritability Apgar 1 minute** = *cry or active withdrawal*
- **Color Apgar 1 minute** = *body pink, extremities blue*
- **Apgar score 1 minute** = *9*
- **Heart rate Apgar 5 minute** = *greater than 100 beats per minute*
- **Respirations Apgar 5 minute** = *good, strong cry*
- **Muscle Tone Apgar 5 minute** = *active motion*
- **Reflex irritability Apgar 5 minute** = *cry or active withdrawal*
- **Color Apgar 5 minute** = *body pink, extremities blue*
- **Apgar score 5 minute** = *9*

To document, click **Sign** ✔ icon.

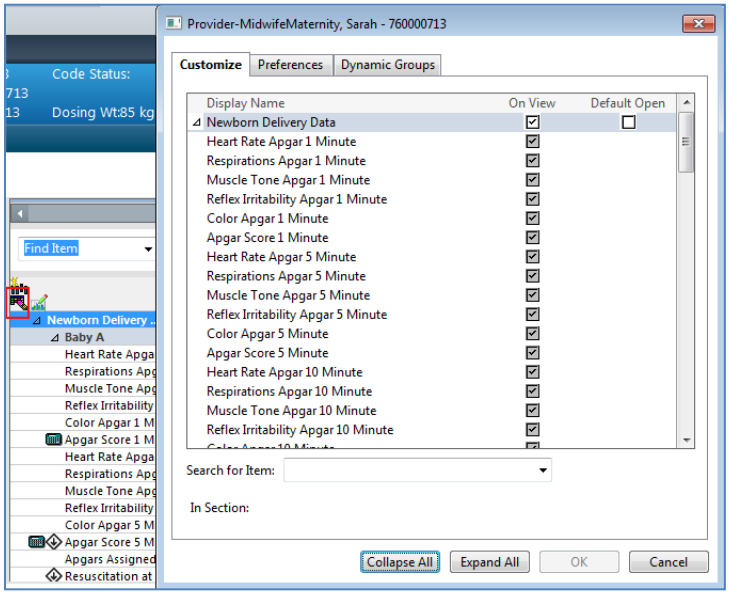


4 Review iView icons

The Calculation icon denotes that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for calculation.

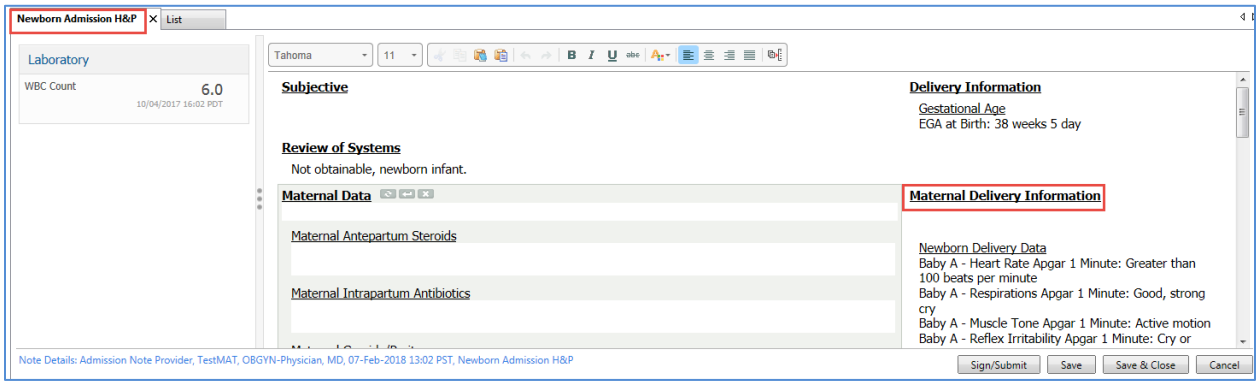


Click the **Customize View** icon  to search for a section not displayed.



Remember: the Newborn Delivery documentation is entered into iView and will flow into your **Newborn Admission Note**.

This **Newborn Delivery** documentation is entered on the Labour workflow tab and the Labour Assessment component.



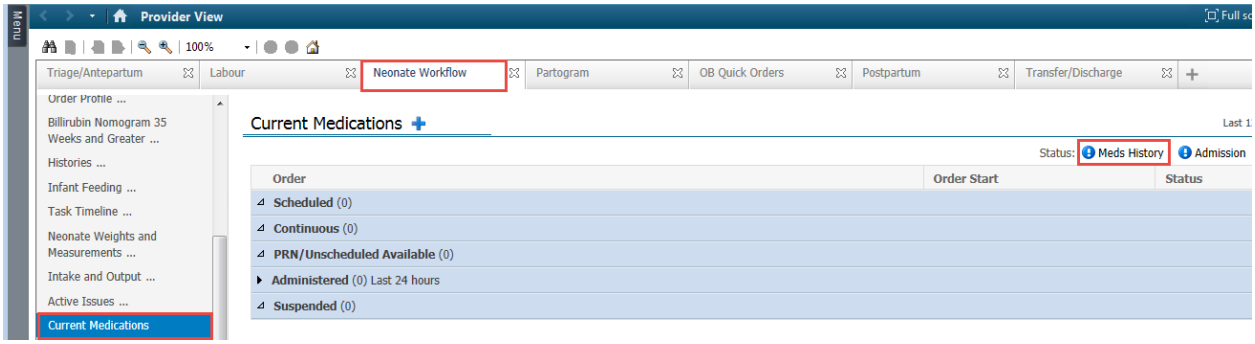
At the time of this workbook's printing, the workflow for documenting a **Newborn Admission Note** is changing. The new system will use **Quick Chart** which is not currently online. Please review the online **Quick Reference Guide** once available.

Activity 5.3 – Review and document the Newborn BPMH

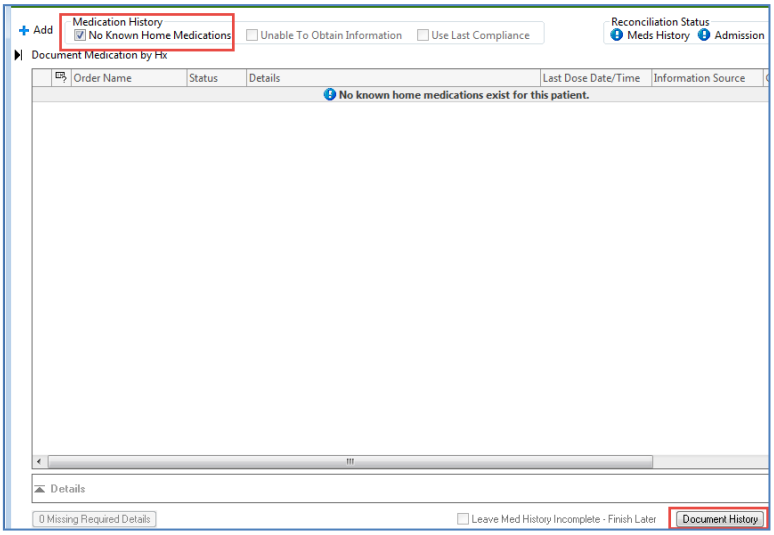
1 This is done from the **newborn's chart**

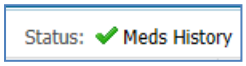
Locate the **Neonate Workflow** tab and select the **Current Medications** component. Click on the

Meds History from the Status line.



2 In the Medication History check box, click **No Known Home Medications.** Then select **Document History.**



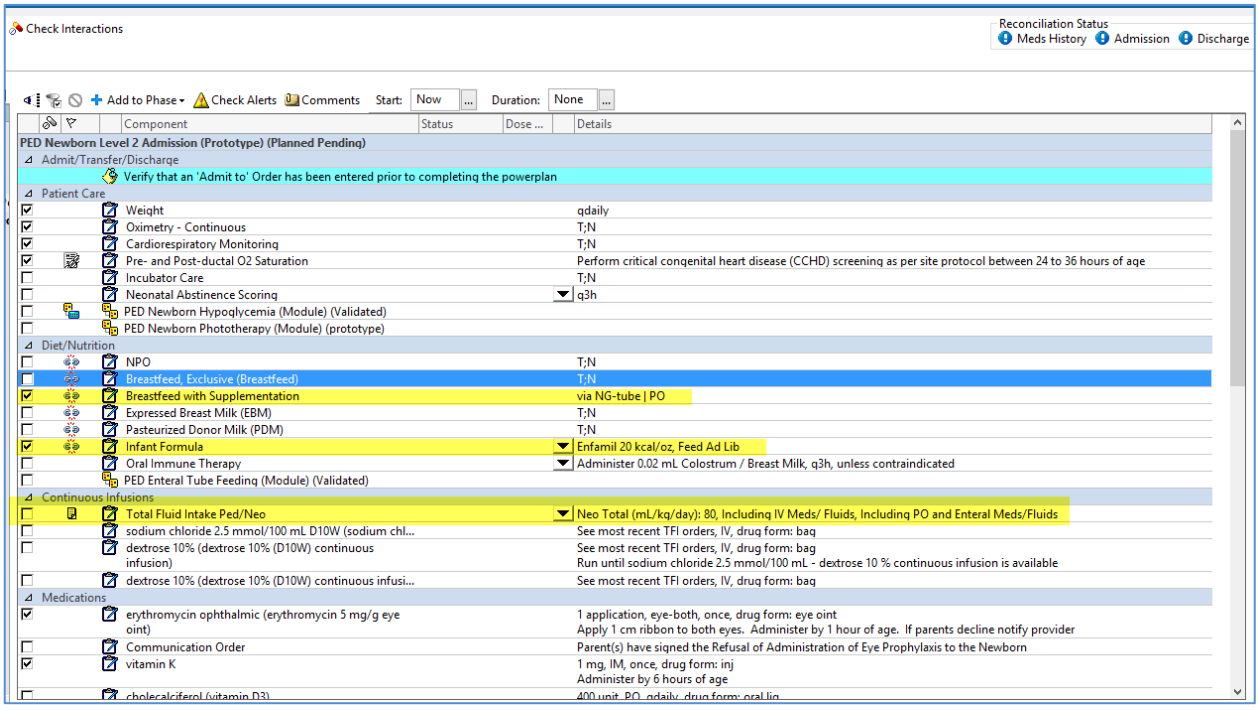
Refresh your screen . Now the BPMH is competed. 

Activity 5.4 – Placing Feeding Orders

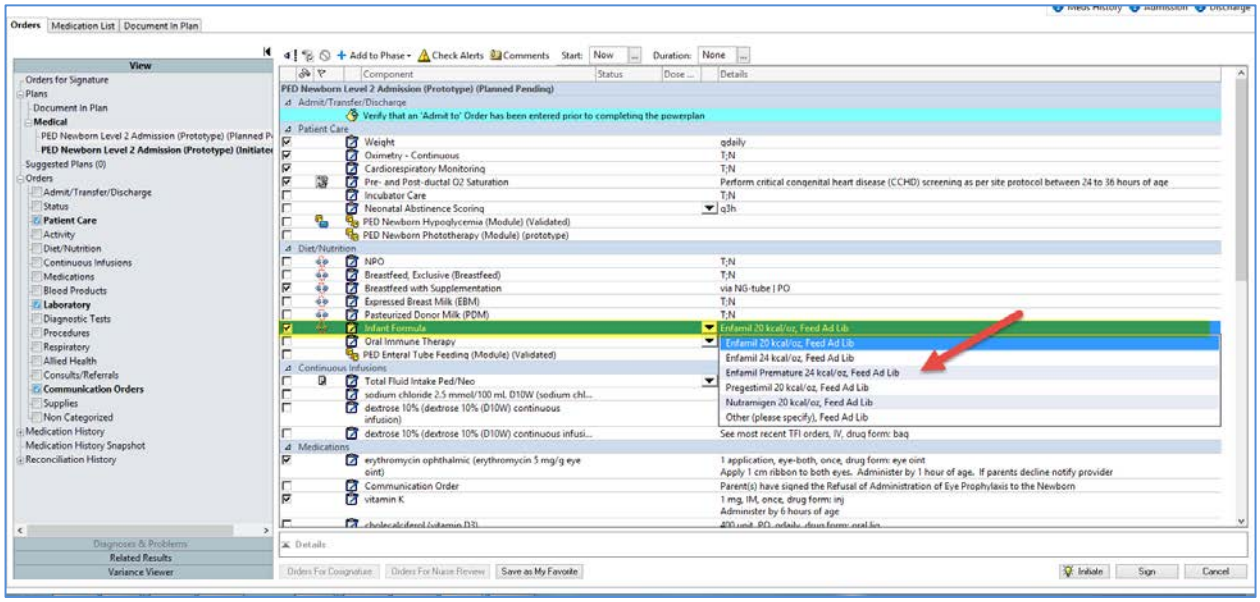
1

Feeding orders are built in the **Powerplan PED Newborn Level 2 Admission (Prototype)** under **Quick Orders**. PED Enteral Tube Feeding Module and Total Fluid Intake can also be accessed under the Patient Care Tab, under the Diet folder.

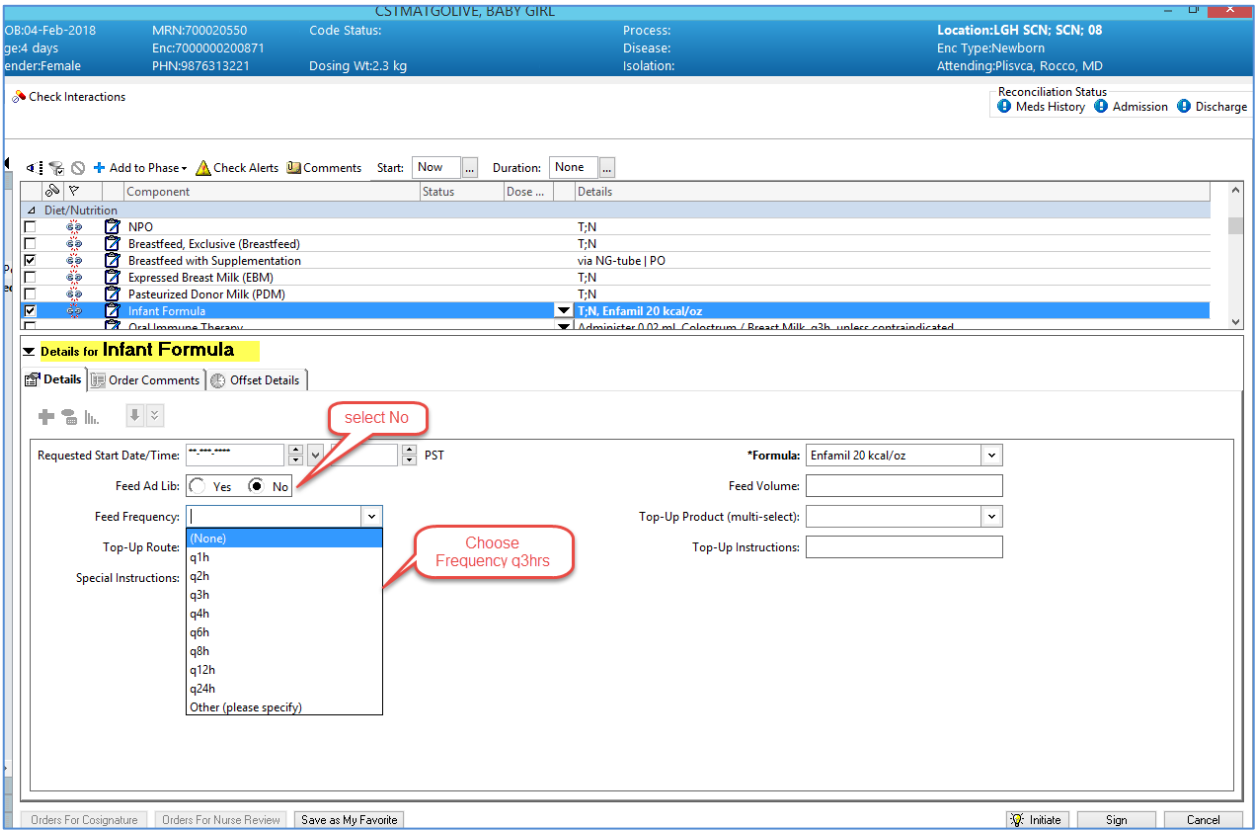
Once this PowerPlan order has been placed, you can modify it as you have learned in a previous activity.



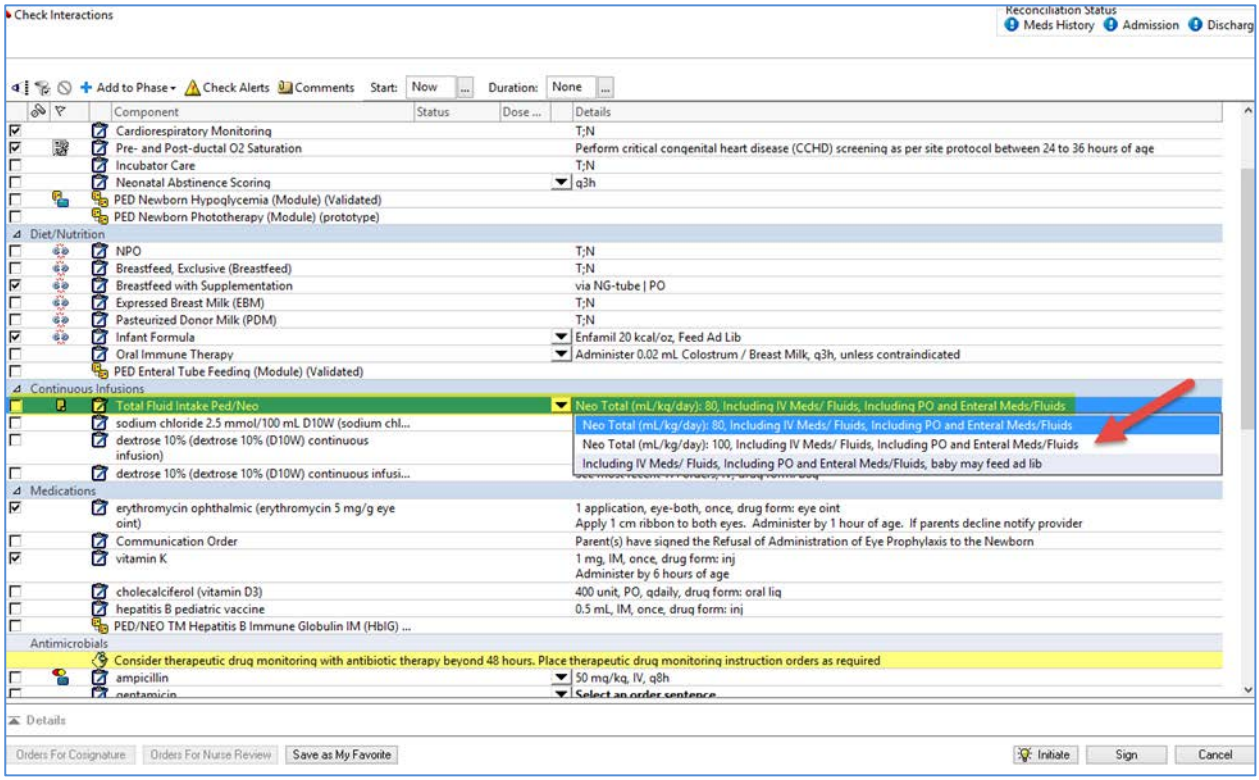
2 If you are ordering Infant Formula, the default order is Enfamil 20kcal/oz. The black triangle will provide a drop down list of other formulas which can be selected.



This order of Enfamil 20kcal/oz can be altered from ad lib to preferred frequency. If you wish to set a feeding schedule, select **Feed Ad Lib: *No***, then select the frequency.

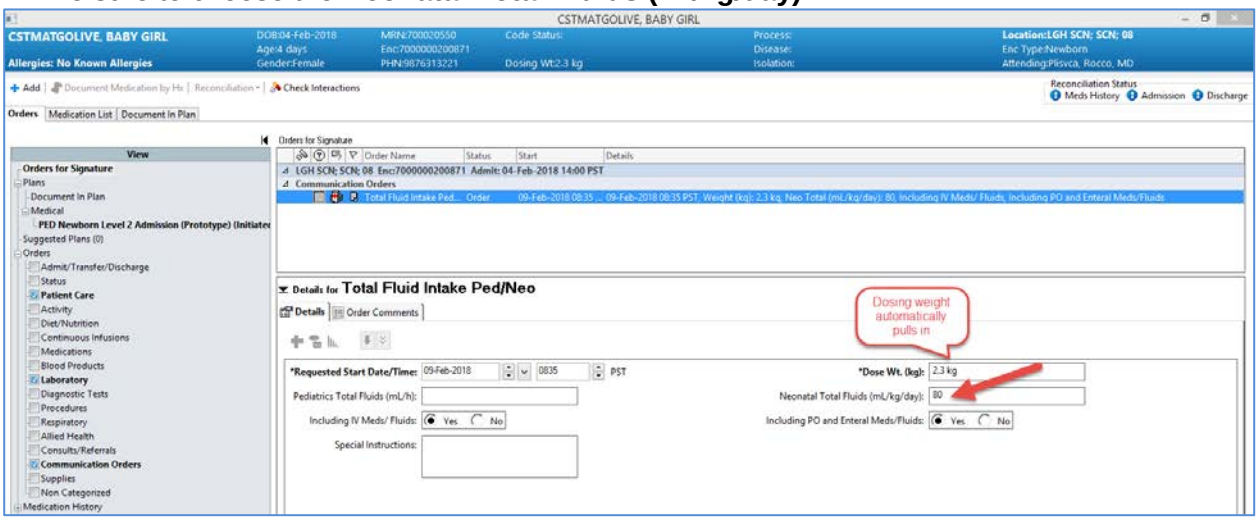


3 **Total Fluid Intake** has been set with a default to 80ml/kg/day but this can be modified as needed. If you click on the triangle, it will give you a drop down list of alternatives.

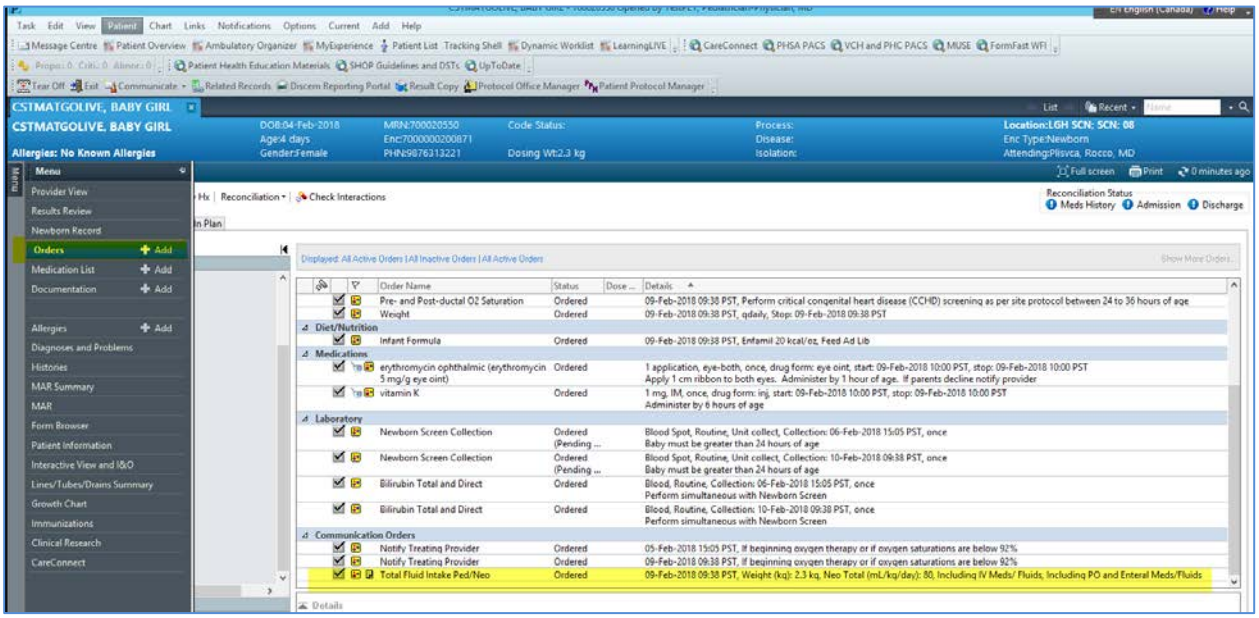


This is the **Total Fluid Intake (TFI)** for the baby. You can change the TFI manually if you click in the box and enter a new TFI.

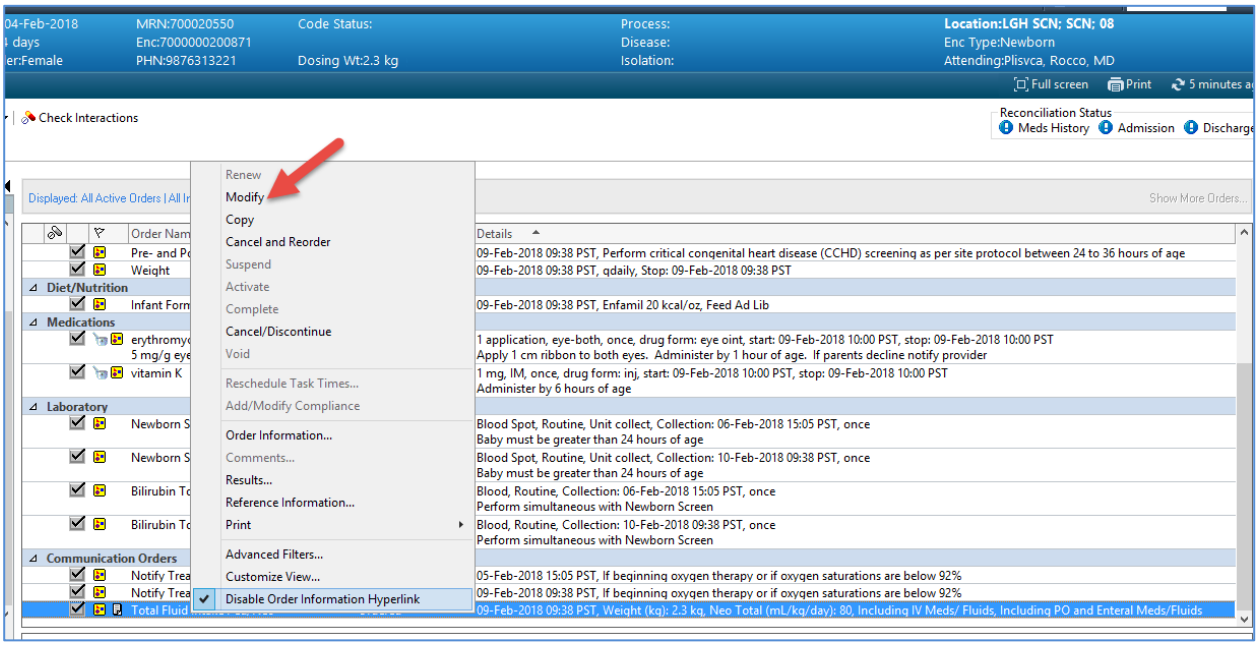
- Be sure to choose the **Neonatal Total Fluids (ml/kg/day)**



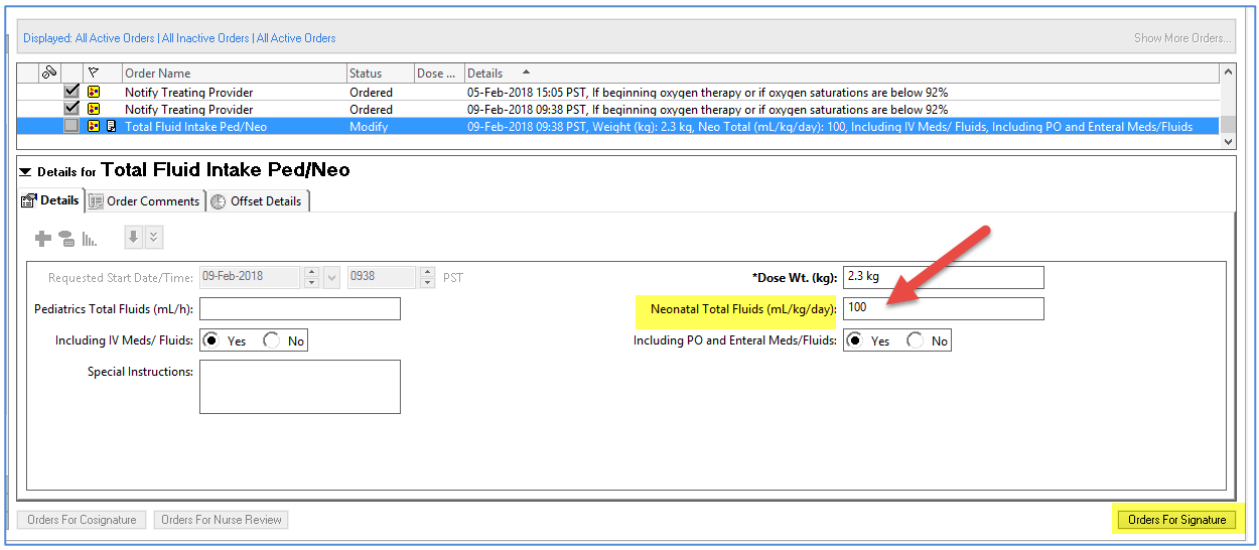
4 Orders can be modified on the **Menu** under **Orders** on subsequent days.



Right click on **Total Fluid Intake Ped/Neo** and **Modify**.



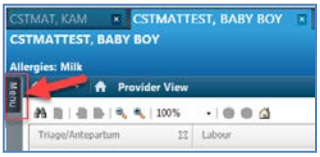
Modify **Total Fluid Intake Ped/Neo** to 100 ml/kg/day:



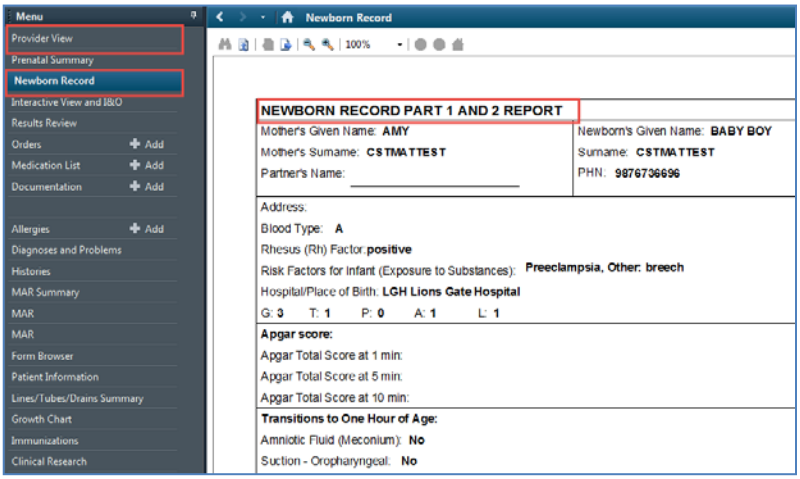
Activity 5.5 – Locate the Newborn Record Report

1

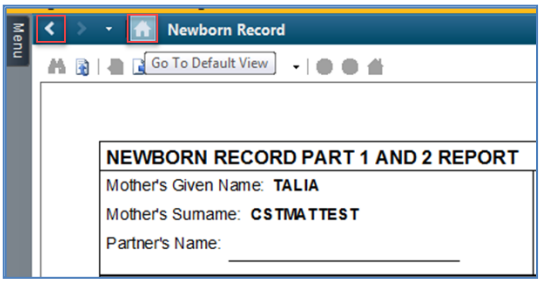
You can locate reports such as the **Newborn Record** in the **Menu** list of the **newborn's chart**. To open, simply click on the **Menu.**



The information is pulled from documentation areas such as iView.



After reviewing the newborn's record, click the **Go To Default View** icon or the **Back** icon to return to your previous page.

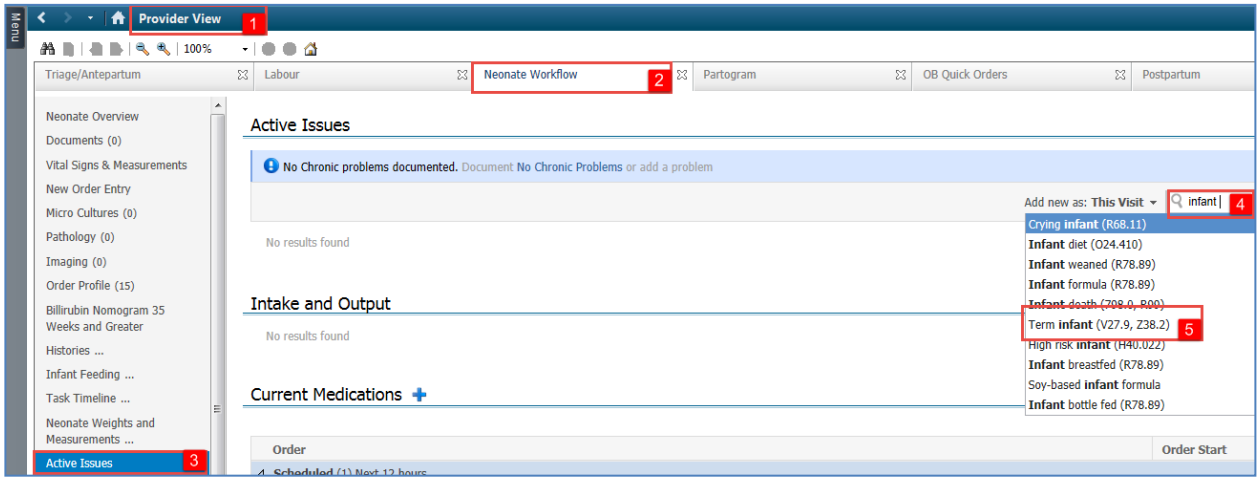


Activity 5.6 – Active Issues for the Newborn

1

The newborn needs a diagnosis recorded as a base for future visits.

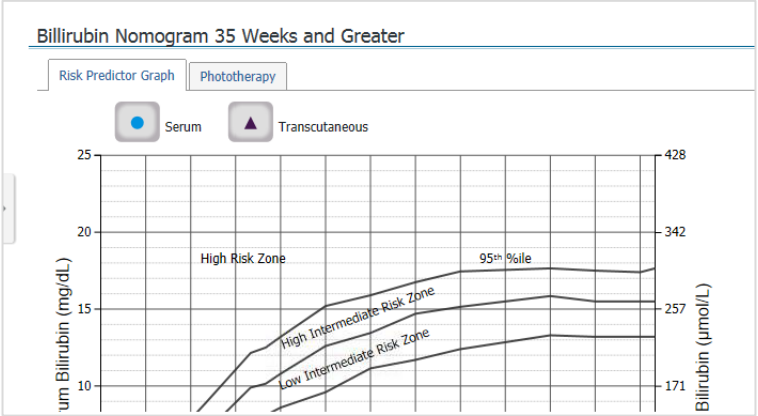
1. Navigate to the **Provider View** of the newborn's chart
2. Click on **Neonate Workflow** tab
3. Click on **Active issues** component
4. In the **Add new as: This Visit** search box, enter = ***Infant***
5. Select **Term Infant**



Activity 5.7 – Bilirubin Nomogram

1 It is important to note that the nomogram should only be considered accurate for infants above 35 weeks of age. It includes data from serum bilirubin and nursing documentation.

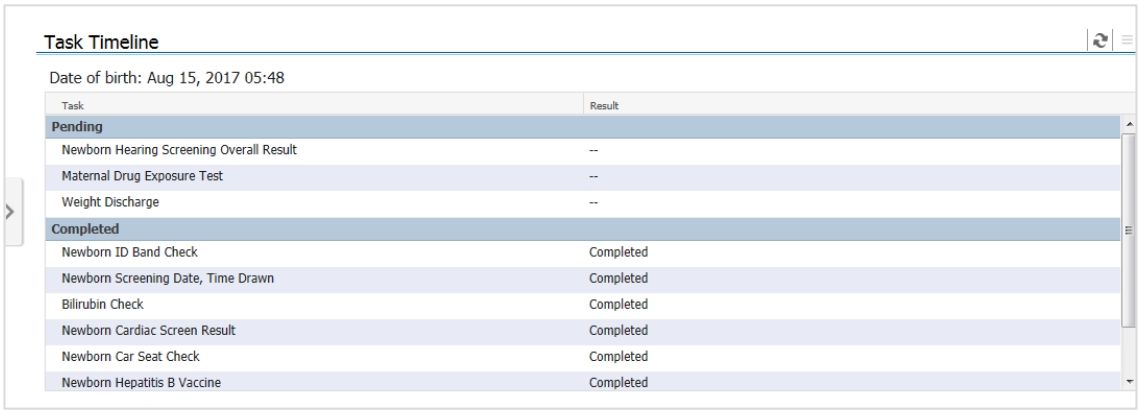
1. Click the Bilirubin Nomogram heading on the Neonate Overview menu.



Activity 5.8 – Task Timeline

1 The Task Timeline tracks key assessments and tasks needed prior to discharging a newborn home. Documentation will flow into the timeline as it is charted by interdisciplinary staff members.

1. From the **Neonate Overview** tab, click Task Timeline and review.



ADDENDUM – Newborn Result Copy and Related Records

Learning Objectives

At the end of this Scenario, you will be able to:

- Result Copy from the mother's chart to the baby's chart.
- Access related records

SCENARIO

Result Copy and Related Records are specific to Maternity settings and are activities involving both the mother's chart and the newborn's.

The following activities are added as an addendum because Result Copy will most often be done by *the nurse or a unit clerk* shortly after the newborn's birth. However, providers do have this functionality should they wish to use it. Because it is usually part of the nurse or unit clerk's workflow, it is advisable to alert them should you wish to Result Copy yourself.

Note that this addendum is outside the pediatric patient scenario used in this workbook, therefore the information provided here is for your information only (*you do not need to execute these activities; reading through is sufficient*.)

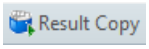
As an inpatient nurse you will be completing the following activities:

- Result copy from the mother's chart to the newborn's chart, prior to transfer.
- Access related records
- **There are 3 minimal times when result copy is necessary:**
  1. After the baby has been quick registered
  2. When the mom and baby is being transferred from labour to postpartum
  3. Prior to the mom and baby being discharged from the hospital.

Result Copy

1

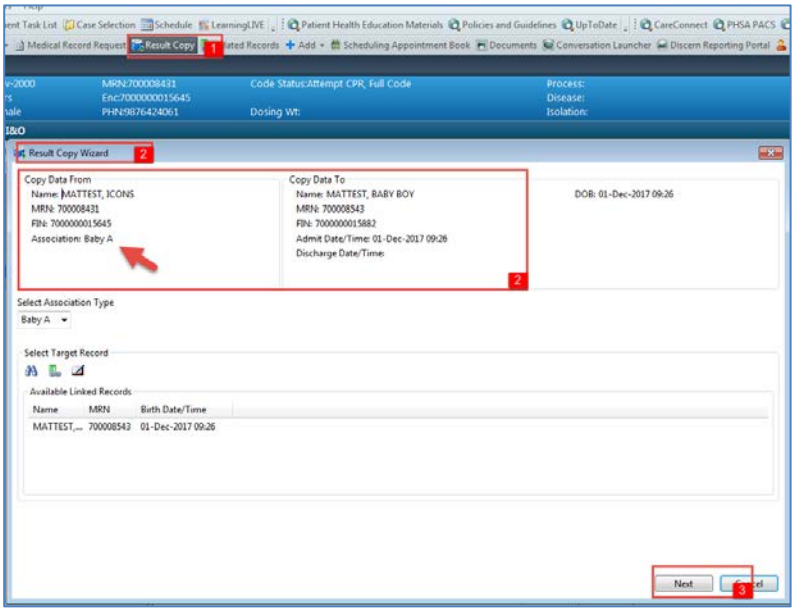
After you have quick registered a baby, it is important to **Result Copy** from the mom's chart to the baby's chart. Performing Result Copy ensures that pertinent delivery and newborn information documented in the mom's chart is copied over to the baby's chart.

1. From the mom's chart, click the **Result Copy** 

in the Toolbar.
2. The **Result Copy** Wizard window opens. Check to ensure the demographic information is correct for both the mom (in the Copy Data From box) and her newly quick registered newborn (in the Copy Data To box).

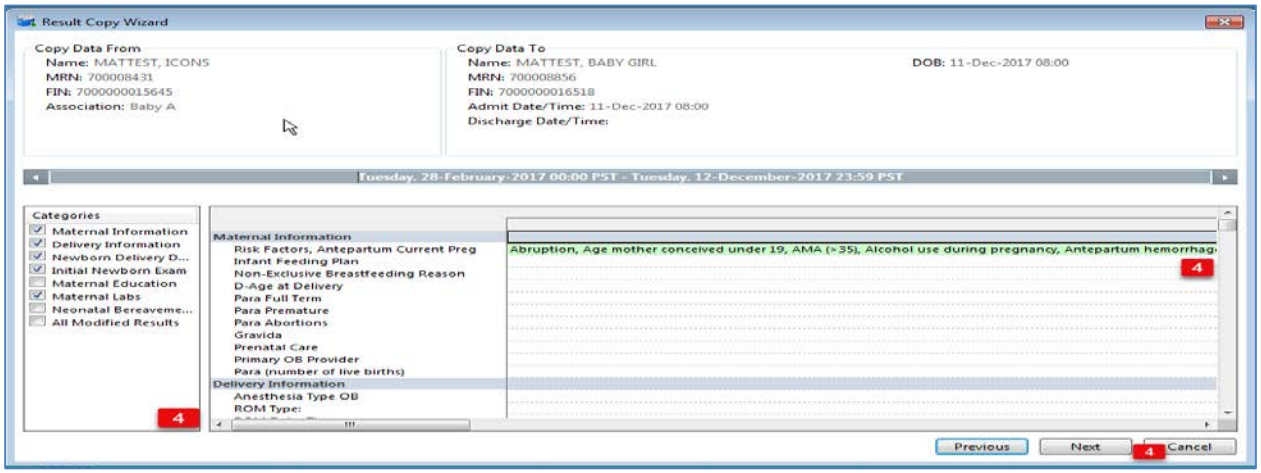
Note: for multiples, ensure the Association field in the Copy Data From box is referring to the correct Baby.

3. Select **Next**.

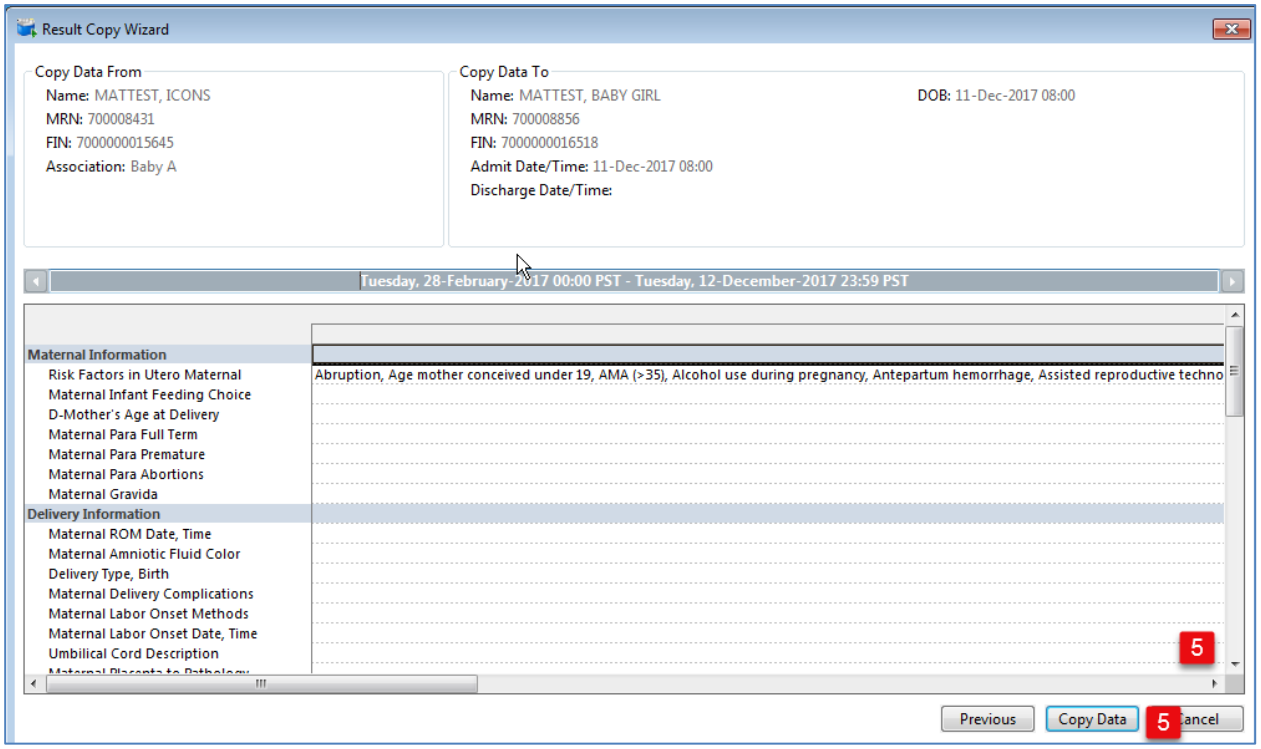


4. Information that will be copied over will show up once more; verify it is accurate. Any information that is highlighted green is newly documented information that will be copied over to the baby's chart. You can select or unselect any categories on the left.

   Select Next.



5. Click **Copy Data**



The Result Copy Wizard window will close and you will be taken back to your patient's (mom's) chart.

Note: Result Copy can be done at any time during nursing documentation, however, at a minimum, it should **always** be done at the following times in order for appropriate information to be viewable in the newborn chart (and therefore facilitate appropriate care):

1. After Quick Registration of a newborn (Labour and Delivery Nurse to do Result Copy)
2. When mother's status is switched from Labour to Postpartum (Labour and Delivery Nurse to do Result Copy)
3. Before mother/baby is discharged from hospital (Postpartum Nurse to do Result Copy)

Now that you have created an electronic chart for the baby (via Newborn Quick Reg) and you have performed result copy to copy pertinent delivery information from the mom's chart to the baby's chart, you can document on the baby. After a baby is born, the nurse needs to complete the Newborn Admission History PowerForm.

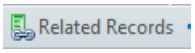
Key Learning Points

- Result copy allows you to copy documented information from mom's chart over to the newborn's chart.
- Result copy is necessary at minimum during the follow 3 situations:
    1. When the newborn has been quick registered
    2. When mom and baby are being transferred from labour to postpartum
    3. When mom and baby are being discharged from the hospital

Related Records

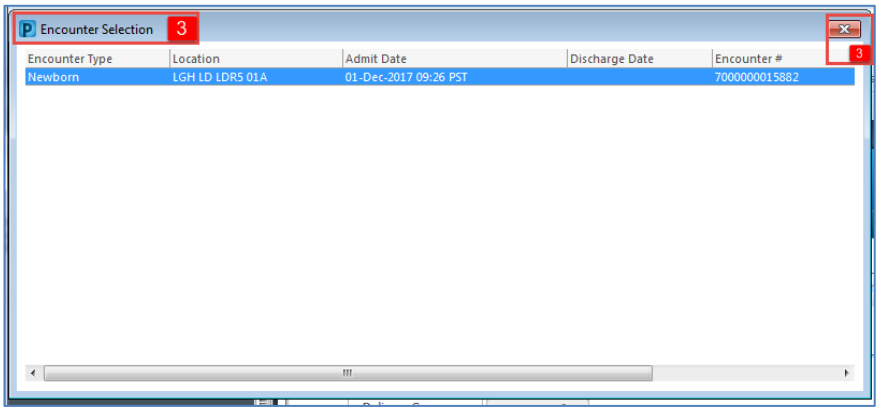
The **Related Records** function can be used to find and open a chart of a related patient. For example, if you are in a mom's chart and you wish to quickly find and open her baby's chart, you can use the Related Records function.

Let's practice using **Related Records** to open a baby's chart:

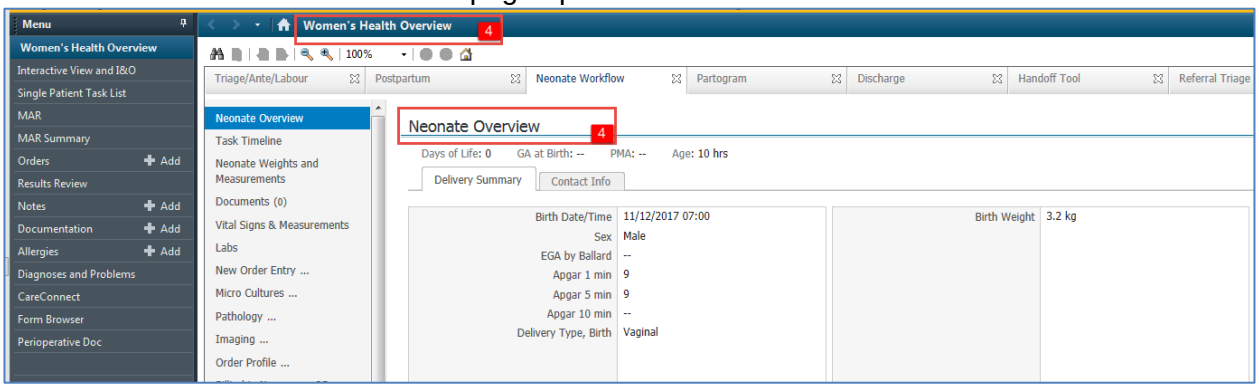
1. From the mom's chart, click on the **Related Records**  from the Toolbar.

2. If this is your first time accessing the newborns chart, you will first be prompted to assign a relationship to the baby. Select Nurse. Click **OK**

3. The Encounter Selection window will open. Select the correct encounter (note that because the newborn only has one encounter, it will already be selected). Click on the X icon  to close the window.



4. The baby's chart will open to the **Women's Health Overview** as the default landing view, with the **Neonate Overview** page open.



End of Workbook

You are ready for your Key Learning Review. Please contact your instructor for your Key Learning Review.